Heart Failure Specialist Nurse
Service Operational Procedures
Acute and Community Setting

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Contents

Introduction 3

Heart failure specialist nurse (HFSN) hospital in-patient management/discharge planning 4-7

Routes and eligibility criteria for HFSN service (community/hospital out-patient clinic) 8

Patient journey through the HFSN service (admission to discharge) 9-13

Appendices 1-22 14-37

1. Initial patient assessment
2. Medication adjustment/prescribing process for non-medical prescribers and non-prescribers
3. Initiating delivery of palliative care for heart failure patients
4. Psychological support and 3DLC team referral pathway
5. Cardiac rehabilitation referral pathway at Kings College Hospital
6. Cardiac rehabilitation referral pathway at Gus and St Thomas’ Hospital
7. a) Patient/carer education and resources
   b) Patient/carer education and resources (Table 1)
8. Information to be added to all patient discharge summaries
9. Referral proforma to community HFSN team
10. Referral to HFSN team from cardiology out-patient clinics
11. Heart failure preserved ejection fraction referral process
12. Patient ineligible for the community HFSN service template letter
13. Follow-up triage by the HFSN (traffic light criteria)
14. Patient declines support of the HFSN service template letter
15. Criteria for home visit by HFSN community team
16. a) GP follow up template letter
   b) Information to be included in GP letter
17. Unable to contact patient template letter
18. Patient did not attend template letter
19. Patient discharged from the HFSN service template letter
20. Minnesota Living with Heart Failure Questionnaire
21. GAD - 7 Questionnaire
22. PHQ – 9 Questionnaire
Introduction

This document provides a guide to the core operational processes required to be followed by the Heart Failure Specialist Nurses (HFSNs) working at King’s College Hospital NHS Foundation Trust, Guy’s and St Thomas’ Hospital NHS Foundation Trust and the community HFSNs (employed by Guy’s and St Thomas’ but serving both Trusts). The document should be used in conjunction with the HFSN Service Competency Framework and approved designated patient resources. Specialist practice and research activities performed by the HFSNs are documented separately.

The HFSN team work closely with the wider HF multi disciplinary teams (MDTs) at KCH and GSTT. Historically the HFSN roles have differed but the Integrated Heart Failure Service aims to standardise the roles and pathways where possible and share learning and practice. However, some variation in processes are inevitable due to the different skill mix of the team and the current different organisational structures. Any variations between the two sites are highlighted throughout this document. The document also provides a guide to the process and pathways to other services and healthcare professionals working outside the HFSN service.

At GSTT the HFSNs coordinate the management of patient’s attending the ambulatory heart failure unit. The processes for the ambulatory unit are available in a separate Service Operational Procedure document.
HFSN hospital in-patient management/discharge planning

**Patient Identification**
- Identify patients with a diagnosis of heart failure (HF) reduced ejection fraction (HFrEF) admitted to cardiology and other medical/care of the elderly wards
- Patients with HF preserved ejection fraction (HFpEF) can be referred following an assessment by a consultant cardiologist/care of the elderly care consultant with an interest in HF (a management plan must be in place)

**In-patient management/education/self-care**
- Allocate all patients with HFrEF a named HFSN
- See new patients following a cardiologist review within one working day of referral
- See patients with a previous known diagnosis within one working day of referral
- Assess modifiable factors in patients with a previous history of readmission and address accordingly
- Review patients with HFrEF at least once per week (in accordance with clinical status)
- Support ward teams to manage patients with HFrEF - offload fluid/adjust diuretics and up-titrare evidence based HF therapy
- Support ward teams in the management of patients with HFpEF in accordance with the management plan written by the consultant cardiologist/care of the elderly consultant with an interest in HF
- Educate the patient throughout the admission tailored to their individual needs

**Discharge planning**
- Assess patients physical/psychosocial needs, set agreed goals and create a management plan with the patient to compliment the physician discharge letter
- Ensure there is HFSN input into the management plan in both cardiology and non-cardiology wards
- Document rationale for out-patient referral to HFSN community team or HFSN hospital out-patient clinic/and or other out-patient teams/services
- Complete referral form/s for appropriate team/service
- Telephone the team the patient is being referred to discuss the management plan prior to discharge and document in the clinical notes (only patients registered with a GP in Southwark and Lambeth)

**Referral**
- Community HFSN team (for majority of patients with HFrEF)
- HFSN hospital outpatient clinic for appropriate cohort of patients (document rationale)
- Other teams/services as appropriate following local guidance
- Patients registered with GPs outside of Southwark and Lambeth should be referred to appropriate CCG teams
**HFSN hospital in-patient management/discharge planning**

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<th>Activity</th>
<th>Process</th>
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| Identification of patients admitted with a diagnosis of HF in (cardiology and non-cardiology wards) | • Patients with HFrEF are referred to the HFSN team from all wards and departments  
• KCH and GSTT identify patients via electronic referral after echo and referrals from the HF consultant ward round  
• KCH patients are always seen by a cardiologist prior to handover to the HFSN  
• GSTT also identify patients via physiologist/nursing led NT Pro BNP screening  
• Patients with HFpEF can be referred following assessment by a consultant cardiologist or care of the elderly consultant with an interest in HF (a management plan must be in place)  

**LVEF ≤ 40% = LVSD - treat with evidence based therapy**  
**LVEF ≥ 50% = HFpEF - offload with diuretics and manage comorbidities**  
**LVEF 41-49% = HFmrEF - no evidence base, therefore treat as HFpEF**

| Variance in type of HF patients managed by HFSNs                              | HFSNs see patients with:  
• LVSD post cardiac surgery  
• Peri/post-partum cardiomyopathy  
• Cardio-oncology  
• Advanced kidney disease if a clear management plan is in place, discuss progress at multi-disciplinary (MDT) meetings and regular review  
• Patients with inoperable valve disease or who have declined surgery (patients with valve disease who are likely to need intervention are referred to cardiology/valve teams)  

| HFSN in-patient assessment                                                                 | Allocate all patients with HFrEF a named HFSN  
• Patients with HFpEF can be referred following an assessment by a consultant cardiologist/care of the elderly consultant with an interest in HF. A clear management plan must be in place  
• See new patients following the cardiologist review within one working day of referral  
• See patients with a previously known diagnosis within one working day of admission  
• Undertake an initial assessment for all patients (Appendix 1)  
• Assess modifiable factors in patients with a previous history of readmission and address accordingly  

| HFSN in-patient management                                                                 | Support ward teams as required to manage patients with HFrEF:  
  – advise on fluid offload/titrating diuretics and changing from intravenous to oral diuretics  
  – review patient at least once per week (in accordance with clinical status)  
  – advise on up-titratiion/adjustment of evidence based HF therapy until discharge (in accordance with NICE guidelines)  
  – document rationale for any medication changes  
• Support ward teams to manage fluid offload for patients with HFpEF in accordance with the management plan written by the consultant cardiologist/care of the elderly consultant with an interest in HF  

*The process for non-medical prescribers and non-prescribers in hospital and community settings is outlined in (Appendix 2)*
### HFSN hospital in-patient management/discharge planning

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| **HFSN in-patient management (contd.)** | • Liaise with MDTs accordingly for other comorbidities  
• Support ward staff in the management of HF patients who trigger on NEWS scoring with low heart rate and low blood pressure requiring evidence-based therapies  
• Provide ongoing assessment of the patient’s physical, psycho-social needs, set agreed goals and create and maintain a tailored management plan  
• Review comorbidity burden and potential for conflicting advice  
• Undertake peer review of case loads in the acute setting (daily/weekly as required) |
| **Liaison with other teams/services** | • Liaise and discuss where appropriate with other teams/services during admission through MDTs, direct referrals and discussion with other specialists for advice and support  
  - process for initiating delivery of palliative care for HF patients (Appendix 3)  
  - psychological support referral pathway (Appendix 4)  
  - cardiac rehabilitation referral is via electronic patient record (EPR). The pathway at KCH is outlined in (Appendix 5) and at GSTT in (Appendix 6) |
| **Education/self-management** | • Explain to the patient/family about the HFSN role in hospital and in the community  
• Educate the patient throughout the admission tailored to individual needs  
• Document the content of education covered or not covered from admission to discharge (the educational content is detailed in Appendix 7a,b)  
• Foster self-management during admission, for example, daily weight monitoring  
• Provide information in a manner/language (if available) understood by patient/family and if required, be an advocate for the patient  
• Assess and document the patient’s understanding of HF, their management plan and ability to self-manage (clarify and address any misconceptions, avoiding medical jargon)  
• Support patients who decline invasive interventions advised by physicians and document in the referral letter on discharge  
• Provide all patients on discharge with the contact details of the HFSN who will follow them up and designated HFSN educational materials, outlined in (Appendix 7a,b) |
| **Discharge from cardiology and non-cardiology wards** | • Assess the patient’s physical/psycho-social needs, set agreed goals and create a management plan with the patient  
• The details of the information to be provided on discharge is outlined in (Appendix 8) and should be included in:  
  - the physician discharge letter from GSTT  
  - the referral form from KCH  
  - the referral to any other clinical service  
• Complete a referral form if the patient is being referred to the community HFSN team and copy to the GP (Appendix 9)  
• Document the rationale in the EPR for referral to the HFSN community team or HFSN hospital outpatient clinic. (A cohort of patients will not be suitable for community HFSN follow-up)  
• Document exceptions if the patient is not on evidence based HF therapy i.e. reasons/contraindications (Appendix 8)  
• Check the discharge letters/referral forms are searchable on the electronic patient record (EPR) |
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| Discharge from cardiology and non-cardiology wards (contd.) | • Telephone the team the patient is being referred to prior to discharge and document in the clinical notes (only patients registered with a GP in Southwark and Lambeth)  
  • Telephone patients who are being followed up at the hospital HFSN out-patient clinic within two working days of discharge and document in the clinical notes  
  • Identify patients at high risk of readmission and advise the community HFSN/GP to review within one week  
  • Ensure patients under the care of the HFSNs who require their blood chemistry to be checked within one week are aware of the need to have a blood test:  
    - add this information to the patient’s medical discharge plan  
    - advise ambulant patients how they can have their out-patient blood test e.g. at the hospital phlebotomy service/GP practice  
    - make an EPR referral to the district nurse for patients who are non-ambulant (mark as urgent)  |
| Referral to other teams/services | • Refer patients registered with GPs outside of Southwark and Lambeth to appropriate CCG teams or if required to the GSTT/KCH HFSN hospital outpatient clinic  
  • Refer to other teams/services (e.g. palliative care, social services, psychology) as appropriate following local guidance |
| Data Collection                  | • Collect required data for National Institute for Cardiovascular Outcomes Research (NICOR)                                                                                                                                                                                                                                               |
| HCP Education                   | • Deliver education about HF and its management to other teams and services                                                                                                                                                                                                                                                                |
Routes and eligibility criteria for HFSN service
(community or hospital out-patient clinic)

**Patient self-referral - if known to the community team**

**Referral from GP - if condition deteriorating or complex titration needs (Appendix 9)**

**Referral following hospital admission (Appendix 9)**

**Referral from other teams/services e.g @Home Team (Appendix 9)**

**Referral from cardiology out-patient clinics (Appendix 10)**

---

**HFSN Service – Eligibility Criteria**

- Confirmed diagnosis of HFrEF determined by imaging (echocardiogram/MRI) and formal report available
- Patients with HFpEF must be under a consultant cardiologist/care of the elderly consultant with an interest in HF in the first instance with a clear management plan in place. If appropriate the patient can then be referred to the HFSN service

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**Referral to community HFSN team**

Majority of eligible HF patients in Southwark and Lambeth should be referred

**Referral to HFSN hospital out-patient clinic**

- A cohort of patients who will not be suitable for community HFSN follow up (rationale documented on EPR)
- Patients registered with a GP outside of Southwark and Lambeth where there is not an HFSN can also be referred

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**Exclusion criteria**

- Patients registered with a GP outside Southwark and Lambeth (N.B. this applies to the community HFSN team only)
- Patients who decline the support of the service
- Other immediately life threatening illness, for example, advanced malignancy
- End stage renal disease (CKD V eGFR <15)
- CKD 1V at discretion of cardiologist and renal team eGFR>15 (must have a management plan)
- Patients on dialysis
- Immediately post-MI unless the patient has previously had the support of the service (or if the ejection fraction is ≤30%
Patient Journey through the HFSN Service (admission to discharge)

**Admission to Service**
- Allocate patient a named HFSN
- Assess and triage patient by telephone within two working days of receiving referral
- Triage patients as per traffic light system for timing of follow up (Appendix 13)
- Document rational for triaging follow-up to community clinic, home visit or HFSN hospital out-patient clinic
- Patients with HFrEF not under the care of a consultant cardiologist must be referred in the first instance to a HF consultant cardiologist or care of the elderly consultant with an interest in HF who will review and refer the patient if

**Management**
- Patients with HFrEF - optimise evidence based HF medication as per guidelines (aim for 80% of case load optimised within 3-4 months) and adjust diuretics as appropriate as per guidelines
- Patients with HFrEF - follow cardiologist management plan
- Update the GP following every clinic or home visit (letter must be sent within two working days), if the patient is taking a long time to optimise document the reason
- Ensure any immediate actions are phoned and communicated by letter to the GP as soon as possible, at least within one working day (Appendix 16a,b)
- Discuss problematic patients at MDT meeting
- Arrange rapid medical review for patient’s deteriorating in the community, same day or following day (Monday-Friday)
- Follow modular approach to education tailored to individual patient’s needs and agreed goals
- Refer to and liaise with other services as appropriate (e.g. Psychology @Home Team)
- Call the patient if they did not attend a clinic to elicit reason and offer another appointment

**Discharge to other teams/services where appropriate**
- Work jointly
- Discuss with other specialists for advice

**Discharge from HFSN Service**
- Patient optimised on maximum tolerated doses of evidence based HF medications and symptoms stable for one month
- Patient failed to respond following two invites for an appointment (Appendix 17)
- Patient did not attend two consecutive appointments with no valid reason (Appendix 18)
<table>
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<th>Activity</th>
<th>Process</th>
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| **Admission to HFSN service** | - Allocate the patient a named HFSN  
- Review referral to ensure:  
  - the patient meets the service eligibility  
  - a confirmed diagnosis and formal echo/MRI report is provided  
- Patients with **HFpEF not** under the care of a consultant cardiologist must be referred in the first instance to a HF consultant cardiologist or care of the elderly consultant with an interest in HF who will review and refer the patient if appropriate directly to the community HFSN team (the referral process is outlined in Appendix 11)  
- Send an acknowledgement that the referral has been received  
- If the patient is not eligible for the HFSN service an email should be sent to the GP (the content of the email is outlined in Appendix 12)  
- Assess and triage the patient by telephone within two working days of receiving the referral  
- Follow up time triaged according to the traffic light system (Appendix 13). All red referrals must be seen within ten working days in accordance with NICE guidelines. If the patient is amber/green document in triage clinical note  
- Document rationale for follow-up to community clinic/home visit or HFSN hospital out-patient clinic  
- If the patient declines the support of the service send a letter to the GP (outlined in Appendix 14)  
- Patient must be housebound for consideration of a home visit i.e. visited by the GP at home, unable to go out to shops, bank etc. (See Appendix 15)  
- Ensure patient is aware of and has contact details of the key named HFSN/care coordinator and how to access the HF service Monday-Friday 9am-5pm and who and when to contact out of hours (details provided in the HF service patient information leaflet)  
- Explain the HFSN role and how the HFSN works with the consultant cardiologist’s management plan and MDT support  
- Add a clinical/ e-note with the following information: assessment of breathlessness/functional status, NYHA 1-1V, oedema/weight, place of follow-up - clinic/home visit and if transport required |
| **On-going Management**   | - Assess and document the patient’s clinical and psycho-social status and cognitive ability  
- Monitor blood chemistry and clinical status closely, particularly if there is evidence of biochemical instability, deteriorating symptoms or changes to the medication regimen  
- Update the GP following every clinic or home visit and send a letter within two working days. If the patient is taking a long time to be optimised on HF medications document the reason. The format and content of the letter is outlined in (Appendix 16a,b)  
- Ensure any immediate actions are phoned and communicated by letter to the GP as soon as possible and at least within one working day  
- Refer patients attending the HFSN hospital outpatient clinic to the community HFSN team if they require a home visit (Appendix 9)  
- Send a letter to the GP if unable to contact the patient on two occasions (Appendix 17) |
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<tr>
<td><strong>Collaboration with other teams/services</strong></td>
<td>• Support a palliative care approach where indicated (Appendix 3)</td>
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<td>• Provide psychological support to people with less complex psychological needs, where indicated refer for psychological support, outlined in (Appendix 4)</td>
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<td></td>
<td>• Refer to cardiac rehabilitation if and when appropriate. Process for referral to KCH is outlined in (Appendix 5) and for GSTT in (Appendix 6)</td>
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<tr>
<td><strong>Education/Self-management</strong></td>
<td>• Provide information in a manner/language understood by the patient/family (support with written information in language understood by the patient/family).</td>
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<td>• Follow a modular approach tailored to individual patient’s needs and agreed goals and document what education has already been provided (Appendix 7a,b)</td>
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<td>• Explore the patient’s understanding of HF and treatment plan – clarify and address any misconceptions avoiding medical jargon</td>
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<td>• Explore the patient’s understanding regarding cause of symptoms</td>
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<td>• Support patients in understanding how comorbidities and other conditions affect the management of HF</td>
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<td>• Assess and document the patient’s cognitive, psychological ability to self-manage</td>
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<td>• Explain about monitoring tools and flexible diuretic dosing (where appropriate)</td>
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<td>• Advise on lifestyle, agree plan with the patient for modifiable reversible risk factors and document plan and goals</td>
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<td>• Support and advise patients with cardiac devices and provide an information leaflet (Appendix 7a,b)</td>
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<td><strong>Medicines management/up-titration of therapy</strong></td>
<td>• Provide patients with HFrEF and their families with information on the prognostic role of evidence based HF medications</td>
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<td>• Optimise evidence based HF medication as per NICE guidelines in accordance with process for non-medical prescribers and non-prescribers as per (Appendix 2). Aim for 80% of case load optimised within three to four months</td>
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<td>• Adjust diuretics as appropriate as per guidelines in accordance with process for non-medical prescribers and non-prescribers as per (Appendix 2)</td>
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<td>• Support patients who are able to self-manage their diuretic regime and flexible diuretic dosing</td>
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<td>• Recognise/explore and document intentional and non-intentional non-adherence and refer to/liaise with specialist HF pharmacists as appropriate</td>
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<td>• Provide a prescription for medication changes on day of clinic/home visit or call the GP practice for the prescription or dosette box change within twenty-four hours</td>
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<td>• Provide personalised written information to the patient including the prescription collection plan</td>
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<td>• Document date and when/why medication changed to an alternative medication or stopped/reduced in the clinical reports</td>
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<td>• Report any adverse drug outcomes via yellowcard.mhra.gov.uk</td>
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<td>• Recognise drugs that are contraindicated/relatively contra-indicated, seek advice for an alternative</td>
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<td>• Provide patients with written documentation about avoiding drugs, for example, non-steroidal anti-inflammatory drugs</td>
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<td>• Provide patients with written instruction about action required if they get a volume depleting illness (diarrhoea and vomiting, polyuria etc.)</td>
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| **Collaborative working with HF pharmacists** | • Assess patients referred to the community HFSN team for adherence and medicine review by the HFSN and refer to the HF pharmacists following consent if:  
  - non-adherence has contributed to a recent hospital admission  
  - identified as being non-adherent  
  - newly diagnosed with HF (for adherence advice)  
  - newly started on HF medications  
  - the level of polypharmacy is inappropriate or causing the patient concern  
  • HF pharmacists will review patients in the HFSN caseload to ensure optimisation of all prescribed medications and to recommend de-prescribing where appropriate  
  • HF pharmacists, nurses and cardiologists deliver GP based virtual clinics to ensure:  
    - all patients on the HF register have a confirmed diagnosis, are coded correctly and receiving evidence based medicine where appropriate  
    - new patients are identified and those lost to follow up re-referred to HF services  
  • Undertake virtual clinics to enable HFSNs, HF pharmacists and cardiologists to provide education and support to GP practice staff to up-skill them in HF management |
| **Caseload accountability** | • Ensure the patient is provided at each consultation with a date for next appointment  
  • Send all letters to the GP and the patient within two working days of follow up  
  • Document all telephone interactions to and about the patient in the clinical notes within two working days  
  • Assess barriers/safety of care in the patient’s home  
  • Review the need for ongoing home visits at each visit  
  • Ensure patients can access the HFSN Monday-Friday (9am-5pm) by landline and mobile phone answering message to enable the HFSN to promptly get back to the patient  
  • Cross-cover caseload with HFSN colleague if on leave/day off and provide a summary of any patients requiring contact/ review in your absence to enable seamless care  
  • Ensure clinics are at capacity and monitor and document did not attend rates  
  • Notify lead HFSN if the caseload drops below sixty patients (community HFSNs)  
  • Send an email to the community HFSN team if unable to provide a patient with an appointment within ten working days of discharge to ask if another HFSN has capacity to do the initial assessment  
  • If the patient breaches ten days by declining appointments offered, document in the clinical notes  
  • Call the patient if they did not attend a hospital out-patient/community clinic to elicit reason and document and offer another appointment accordingly  
  • Send unable to contact letter to the patient, copied to the GP after two attempts to contact the patient (Appendix 17)  
  • Send did not attend letter to the referrer and the GP if the patient has not attended two consecutive appointments. Advice offered in the letter is outlined in (Appendix 18) |
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<td>HF Specialist Physician Review/MDT</td>
<td>• Be familiar with consultant cover rota and who to call for advice if required</td>
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<td>• Discuss problematic patients’ and those difficult to optimise at the MDT meeting</td>
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<td>• Arrange a rapid medical review on the same day or following day (Monday-Friday) for patients deteriorating in the community</td>
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<td>• Review caseload regularly and ensure all patients in the community caseload have an annual review with a Kings Health Partners or St George’s cardiologist</td>
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<td>• Attend MDT meetings for support to manage complex patients</td>
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<td>• Regularly review caseload to ensure all patients have a management plan, any patient without a management plan should be reviewed at the MDT meeting</td>
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<td>• Following MDT discussion, it may be decided that the HFSN is not the most appropriate to follow up some HFpEF patients, depending on the severity of other comorbidities. Refer patient to other teams/services accordingly</td>
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<tr>
<td>Criteria for discharging patients from the HFSN service</td>
<td>• Patient optimised on maximum tolerated doses of evidence based HF medications and symptoms stable for one month</td>
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<td>• Patient failed to respond following two invites for an appointment written or telephone communication</td>
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<td></td>
<td>• Patient did not attend two consecutive appointments and no valid reason provided</td>
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<tr>
<td>Discharge process from HFSN caseload/Transfer to GP/other health and social care teams and services</td>
<td>• Plan and clearly communicate transfer of care to the patient and carer prior to discharge from the HFSN service</td>
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<td>• Explore self-management strategies and advise on the range of services that are available, including cardiac rehabilitation and psychological support</td>
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<td>• Ensure the patient understands how to self-manage their condition, and when to seek professionals for help</td>
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<td>• Document exceptions if the patient is not on evidence based HF therapy i.e. reasons/contraindications at discharge (Appendix 19)</td>
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<td>• Provide the patient with contact number for any queries Monday – Friday, 0900-1700 and who to contact and when out of hours (details in the HF service patient information leaflet)</td>
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<td>• State in the final follow up letter at discharge that the patient is now being discharged back to the care of the GP and should be reviewed in six months. The letter should also advise patients that they can self-refer back to the HFSN service if their condition deteriorates (Appendix 19)</td>
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<tr>
<td>Data Collection</td>
<td>• Offer all patients the Minnesota Living with Heart Failure questionnaire on initial contact, at 6 months, at 12 months and on discharge from the HFSN service (Appendix 20)</td>
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<td>• Offer all patients the anxiety questionnaire GAD - 7 (Appendix 21) and depression questionnaire PHQ - 9 (Appendix 22) at every HFSN contact (except initial contact)</td>
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<tr>
<td>HCP Education</td>
<td>• Deliver education about HF and its management to other teams and services linked to the primary care education programme</td>
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<td>• HCP study days organised and presented by the HFSN team for HCPs working in primary and secondary care involved in the management of patients with HF</td>
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**Appendix 1**

**Initial patient assessment**

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<th>Presenting complaint</th>
<th>expressed in the patients’ own words</th>
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<tr>
<td><strong>History of presenting complaint</strong></td>
<td>specifically history of development and duration of heart failure symptoms, together with any contact with other professionals’ pre-hospital</td>
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<tr>
<td><strong>Specific signs and symptoms experienced</strong></td>
<td>ask about:</td>
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<tr>
<td>✓ Breathlessness at rest/on exertion</td>
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</tr>
<tr>
<td>✓ Orthopnoea (number of pillows used / back rest) or paroxysmal nocturnal dyspnoea</td>
<td></td>
</tr>
<tr>
<td>✓ Exercise tolerance with any aids used</td>
<td></td>
</tr>
<tr>
<td>✓ Fatigue</td>
<td></td>
</tr>
<tr>
<td>✓ Chest pain</td>
<td></td>
</tr>
<tr>
<td>✓ Dizziness</td>
<td></td>
</tr>
<tr>
<td>✓ Palpitations</td>
<td></td>
</tr>
<tr>
<td>✓ Falls</td>
<td></td>
</tr>
<tr>
<td>✓ Loss of consciousness</td>
<td></td>
</tr>
<tr>
<td><strong>Follow up questions</strong></td>
<td>to assess any positive responses to the above symptoms being present</td>
</tr>
<tr>
<td><strong>Past Medical History</strong></td>
<td>including any cardiac surgical or percutaneous intervention, identify significant co-morbidities COPD, diabetes, CKD, anaemia, hypertension</td>
</tr>
<tr>
<td><strong>Drug History</strong></td>
<td>including allergies, intolerances, over the counter medication, adherence</td>
</tr>
<tr>
<td><strong>Dietary history</strong></td>
<td>Fluid intake per 24 hrs, nutritional intake and assessment of appetite, BMI</td>
</tr>
<tr>
<td><strong>Modifiable Factors</strong></td>
<td>Identify and address accordingly</td>
</tr>
<tr>
<td><strong>Social History</strong></td>
<td>(including living arrangements)</td>
</tr>
<tr>
<td>✓ Who is at home</td>
<td></td>
</tr>
<tr>
<td>✓ What type of accommodation – i.e. flat, house, which floor? Stairs? and whether managing these</td>
<td></td>
</tr>
<tr>
<td>✓ Access to property – stairs leading up to front door?</td>
<td></td>
</tr>
<tr>
<td>✓ Able to management washing and dressing? Cooking? Shopping?</td>
<td></td>
</tr>
<tr>
<td>✓ Carer involvement? What do they do? Any care package/frequency of any care package?</td>
<td></td>
</tr>
<tr>
<td>✓ Involvement of any other professionals in care i.e. community HFSN</td>
<td></td>
</tr>
<tr>
<td>✓ Occupation, or former occupation</td>
<td></td>
</tr>
<tr>
<td>✓ Any concerns regarding supporting self – receiving any benefits?</td>
<td></td>
</tr>
<tr>
<td>✓ Smoking, alcohol use and recreational drug use</td>
<td></td>
</tr>
<tr>
<td><strong>Psychological assessment</strong></td>
<td>Anxiety and depression evident? Does the patient wish to have help? Document actions taken</td>
</tr>
<tr>
<td><strong>Family History</strong></td>
<td>specifically focussed on cardiovascular events or risk factors</td>
</tr>
<tr>
<td><strong>Examination</strong></td>
<td>JVP, chest auscultation, heart sounds, peripheral oedema and to what level, vital signs, height and weight</td>
</tr>
<tr>
<td><strong>Secondary data</strong></td>
<td>ECG, echo, check if patient has a device and any recent interrogation result, CXR</td>
</tr>
<tr>
<td><strong>Bloods</strong></td>
<td>check the following have been undertaken:</td>
</tr>
<tr>
<td>✓ Renal function</td>
<td></td>
</tr>
<tr>
<td>✓ Full blood count</td>
<td></td>
</tr>
<tr>
<td>✓ Liver function tests</td>
<td></td>
</tr>
<tr>
<td>✓ Thyroid function tests</td>
<td></td>
</tr>
<tr>
<td>✓ HbA1c</td>
<td></td>
</tr>
<tr>
<td>✓ Ferritin and iron binding levels</td>
<td></td>
</tr>
<tr>
<td>✓ Lipids</td>
<td></td>
</tr>
<tr>
<td><strong>Impression</strong></td>
<td>Is the patient stable with regard to HF symptoms? Or are there symptoms i.e. fluid overload that need to be managed? Document the problems that need action as a result of the assessment</td>
</tr>
<tr>
<td><strong>Management Plan</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 2
### Medication adjustment /prescribing process for non-medical prescribers and non-prescribers

<table>
<thead>
<tr>
<th>Non-medical prescribers</th>
<th>In-patient</th>
<th>Community / hospital outpatient clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓ All individual non-medical prescribers will agree a scope of practice with their service lead in accordance with the Trust Non-Medical Prescribing Protocol</td>
<td>✓ Non-medical prescribing in the out-patient / community setting will agree a scope of practice with their service lead in accordance with the Trust Non-Medical Prescribing Protocol</td>
</tr>
<tr>
<td></td>
<td>✓ HFSNs will only prescribe medications licensed for use in HF</td>
<td>✓ HFSNs will only prescribe medications licensed for use in HF</td>
</tr>
<tr>
<td></td>
<td>✓ Scope of practice will include:</td>
<td>✓ Scope of practice will include:</td>
</tr>
<tr>
<td></td>
<td>- initiation and titration of evidence-based HF therapy</td>
<td>- initiation and titration of evidence-based HF therapy</td>
</tr>
<tr>
<td></td>
<td>- initiation and titration of diuretic therapy</td>
<td>- initiation and titration of diuretic therapy</td>
</tr>
<tr>
<td>Community / hospital outpatient clinic</td>
<td>All HFSNs will work towards achieving non-medical prescribing accreditation</td>
<td>All HFSNs will work towards achieving non-medical prescribing accreditation</td>
</tr>
<tr>
<td>Community / hospital outpatient clinic</td>
<td>In the interim all HFSNs will work within NICE Guidelines for Management of Chronic Heart Failure, advising in-patient clinical teams to ‘consider’ titration of evidence based medical therapy and adjustment of diuretics where indicated and safe to do so</td>
<td>In the interim all HFSNs will work within NICE Guidelines for Management of Chronic Heart Failure, advising in-patient clinical teams to ‘consider’ titration of evidence based medical therapy and adjustment of diuretics where indicated and safe to do so</td>
</tr>
</tbody>
</table>

All HFSN should routinely follow up patients after medication changes have been advised to establish the patients response to medication

<table>
<thead>
<tr>
<th>Non-prescribers</th>
<th>In-patient</th>
<th>Community / hospital outpatient clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓ All HFSNs will work towards achieving non-medical prescribing accreditation</td>
<td>All HFSNs will work towards achieving non-medical prescribing accreditation</td>
</tr>
<tr>
<td></td>
<td>✓ In the interim all HFSNs will work within NICE Guidelines for Management of Chronic Heart Failure, advising the GP to ‘consider’ titration of evidence based medical therapy and adjustment of diuretics where indicated and safe to do so</td>
<td>In the interim all HFSNs will work within NICE Guidelines for Management of Chronic Heart Failure, advising the GP to ‘consider’ titration of evidence based medical therapy and adjustment of diuretics where indicated and safe to do so</td>
</tr>
</tbody>
</table>

All HFSN should routinely follow up patients after medication changes have been advised to establish the patients response to medication
Appendix 3

Initiating delivery of palliative care for heart failure patients

**Indications to consider initiation of palliative care**
- Resistant hyponatraemia
- Hypoalbuminaemia
- 3 or more non elective admissions in last 6 months
- NYHA III-IV
- Refractory symptoms despite optimal therapies
- Starting to reduce pharmacological therapies
- Declining renal function
- Would you be surprised if patient died within 6-12 months?

**Next steps**
- Engage HF cardiologist to agree ceiling of treatment
- Gain MDT agreement
- Advanced care planning conversations should be initiated by cardiologist/HF team once agreed
- Preferred place of care/preferred place of death discussed and documented
- DNACPR discussed with patient and put in place as appropriate
- Device switch off discussions should be agreed, documented and forms completed by cardiologist
- Referral to palliative care team with consent of patient

**Referral to palliative care via EPR**
- Community referral to palliative care – forms are on intranet
- Indication of prognosis in referral
- Arrange joint visit with palliative care and HF team
- ‘Coordinate My Care’ record should be jointly commenced prior to discharge
- Cardiologist must document a robust plan of care to ensure parameters for care are understood i.e. – repeating bloods, emergency care etc.

Document all discussions and decisions thoroughly
Appendix 4:

Psychological support and 3DLC team referral pathway

Routine Screening with PHQ9 & GAD7

Suicide ideation flagged? [PHQ9(#9)≥1]

Yes

Perform risk assessment and take appropriate action (see separate guidance)

Add link

No

PHQ9 ≥ 15?
or GAD7 ≥ 10?

Yes

Are mental health symptoms affecting management of or directly related to HF?

Yes

Discuss with 3DLC in MDM or email slm-tr.3_dlc@nhs.net

Offer 3DLC leaflet

Notify GP

No

PHQ9 =10-14?

Yes

Offer IAPT leaflet, encourage self-referral and notify 3DLC & GP

No

Provide education on mind-body supported by recommended written materials and review when next seen

Remember to think about:

1. Patient’s understanding of HF and education materials given
2. The role of HF and treatment on the development/maintenance of depression and anxiety symptoms
3. History of psychiatric diagnosis or services received (if currently receiving care, update their team)
4. Social factors: living condition, isolation, financial strain
5. Substance misuse
6. Cultural & religious background affecting health beliefs and adherence
7. Consent to referral for further mental health assessment or treatment

This guideline should not supersede clinical judgement
### Appendix 5: KCH Cardiac rehabilitation pathway Kings College Hospital

If any queries regarding referrals and inclusion/exclusion criteria  
Please contact cardiac rehabilitation team on 0203 299 3495

**Inclusion Criteria**
- Confirmed diagnosis of heart failure - HFrEF, HFrEF, LVAD, post-transplant
- NYHA class I, II, III
- NYHA class IV- very limited approach would need to be discussed with team if first and agreed with consultant cardiologist
- Stable heart failure and controlled symptoms
- Receiving care from heart failure team
- Willing to attend 12 week programme
- No compliance issues with medications and treatments

**Exclusion criteria**
- Unstable heart failure
- Failure to comply with medications/treatments
- Poorly controlled heart rate and resting heart rate >100 bpm
- High energy pacing device set to be activated at rates achieved during exercise
- Unstable hypertension (systolic >200 diastolic >100)
- Symptomatic hypotension
- New or uncontrolled arrhythmias
- Long QT/QTc
- Recent embolism or LV thrombus and not anticoagulated
- Abdominal aortic aneurysm- to discuss with consultant cardiologist
- Moderate to severe aortic stenosis
- Dyspnoea at rest, new increased dyspnoea & progressive worsening of exercise tolerance in last 3-5 days
- Acute systemic illness/fever
- Active pericarditis/myocarditis
- Regurgitant valvular heart disease requiring surgery
- MI within previous 3 weeks
- Uncontrolled diabetes mellitus
- Severe orthopaedic conditions that would prohibit exercise

1) Referral received from heart failure team/ community heart failure team/ GP with heart failure management plan in place.

Patient’s symptoms need to be stable prior to referral. Can accept referral from inpatients if stable and HF plan in place.

2a) Referral reviewed - invite letter/phone call and programme information sent- Patient to contact team within 14 days

2b) If no response to initial invite further letter sent asking patient to contact team within 7 days

If no response or patient declines refer back to referring team

3) Outpatient clinic -
- Symptoms review
- Medication review
- 6 min walk test/cardiopulmonary exercise testing
- Physio review
- Introduce programme

4) Comprehensive HF cardiac rehab - 12 wk programme includes:
- exercise
- education day
- relaxation
- drug titration
- psychological support

5) Home programme:
- BHF DVD
- or individual programme with physiotherapy follow-up

6) 1 month follow-up after discharge from cardiac rehab

Face to face or telephone clinic dependent on need:
- review symptoms
- current medications
- exercise progression

Discharge from cardiac rehabilitation:
- letter to GP
- refer back to heart failure team if required
- enter onto the National Association for Cardiac Rehabilitation (NACR) database
Appendix 5: Cardiac rehabilitation pathway at Guys and St Thomas’ Hospital

Cardiac Rehabilitation for Heart Failure Patients at GSTT (Phase III)

**Inclusion Criteria**
- Diagnosis of Heart Failure
- Referral discussed with patient who is motivated to attend.
- Appropriate to exercise

**Referrals for Phase III received from**
- Heart Failure CNS
- Cardiologist
- G.P. - With heart failure management plan in place.

**Phase III Assessment Clinic**
- Nurse Assessment
- Clinical assessment
- Symptom management
- Medication review
- Risk stratification for exercise
- Risk factor review
- Goal setting
- OT Assessment
- Functional and psychological assessment
- Energy conservation/pacing
- Relationship issues
- Vocational advice and support
- ED assessment

**Physio Assessment and Shuttle Walk Test**
- Assessment of current and past physical activity
- Assess need for exercise adaptations
- Functional capacity test. Establish training HR
- Set physical activity goals
- Referral to MSK physio if needed
- Education about physical activity

**Phase III programme 2 sessions per week for 6 /52**
- MDT (Nurse, Physio and OT led)
- Group exercise
- Health education
- Relaxation
- Stress management
- 3 week goal review

**Exit assessment**
- Reassess clinical, exercise and psychological status
- Plan onward care
- Referral to MCVHC, etc as appropriate

**Phase IV**
- Community Programme

Discharge from GSTT CR service. Patient may continue under care of cardiologist/IHF services. Letter to GP. Database.

Home Rehab (as staffing allows)
- 6 week programme
- Individualised assessment
- Establish goals
- Prescribed home exercise
- Weekly follow up phone calls

1 year letter to patients to remind them of service
Appendix 7a
Patient/carer education and resources

Who needs education? - patients and carers (educate significant carer if there are cognitive issues)
- Following diagnosis
- If non-adherent to the management plan/if requiring increased support to self-manage
- If additional interventions are added to the management plan (e.g. devices, palliative care)

Timing of education
- At first review following referral to out-patient HFSN
- On day of diagnosis or next working day in the in-patient setting (if patient’s condition is stable)
- Prioritise education to in-patients who are being discharged
- Reiterate education within the 24 hr period prior to discharge

Follow up letters/referrals - document if and why education and resources have NOT been provided in any follow-up letters and referrals to other colleagues/teams involved in the patient’s care

Education resources - provide all patients with the following recommended resources:
1. KHP HF patient passport booklet which provides information about the service and contact details, complimenting existing approved materials and replaces all single paper sheets currently given out
2. KHP patient ID card
3. BHF book ‘Everyday guide to living with heart failure’
4. Patient education films (Sound Doctor)

Education sessions
- The number of sessions depends on individual patient needs and should be delivered by a named HFSN
- Tailor education to documented individual patient goals
- Guide patient to relevant pages in the BHF book ‘Everyday guide to living with heart failure’ and/or if required signpost to other appropriate trust approved resources as outlined in (Table 1). The additional resources should not replace the recommended resources

Initial session
- Assess prior knowledge, understanding of HF condition
- Address misconceptions
- Focus on symptom control, management of oedema with flexible diuretic dosing (if appropriate) and role of prognostic therapies in stabilising condition
- Document patient / carer ability or inability to self-manage a flexible diuretic dosing regimen

Subsequent session
- Reassess understanding of HF condition and role of prognostic drugs
- Reassess patient safety with flexible diuretic dosing (If appropriate)
- Document a modified approach to resources if required, e.g. large print/phone alerts to take their medication
- Educate about the benefit of exercise and daily activities, guided by patient goals and physical ability
- Outline the need for low intensity exercise if moderate exercise is contraindicated

Co-morbidities/lifestyle modification
- Provide education and advise where appropriate about the impact of co-morbidities and lifestyle that can impact on the patient’s condition e.g. obesity, uncontrolled hypertension, gout, excess alcohol, smoking
## Appendix 7b
Patient/carer education resources

### Table 1

<table>
<thead>
<tr>
<th>Core Topics</th>
<th>BHF book ‘Everyday guide to living with HF’</th>
<th>KHP Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to HF</td>
<td>Chapter 1, P5-8</td>
<td>Suite of patient education films (Sound Doctor). Patients can access the films by: emailing <a href="mailto:info@thesounddoctor.org">info@thesounddoctor.org</a> with the name of their GP practice or hospital. The patient will be sent a link to click on and will require to create a username and password</td>
</tr>
<tr>
<td>Symptoms - how to control/ self-management</td>
<td>Chapter 2, 11-19</td>
<td></td>
</tr>
<tr>
<td>Medication and how to manage - Over the counter medication - Herbal medication</td>
<td>Chapter 2, P19-33 Chapter 2, P34</td>
<td></td>
</tr>
<tr>
<td>Managing fluid balance</td>
<td>Chapter 3, P42-47</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Chapter 3, P50-58 BHF Exercise DVD ‘My personal trainer’ for patients who do not attend cardiac rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Additional Topics (if appropriate)</td>
<td>Chapter 3, P37-50</td>
<td></td>
</tr>
<tr>
<td>Lifestyle advice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dietary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Stopping smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Recreational drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-morbidities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Controlling blood pressure</td>
<td>Chapter 3, P37</td>
<td></td>
</tr>
<tr>
<td>Sex/erectile dysfunction</td>
<td>Chapter 4, P77-78</td>
<td>- Refer to erectile dysfunction clinic (if required)</td>
</tr>
</tbody>
</table>

### Work in progress:

The above recommended resources are the core resources used by the HFSN team. The integrated HFSN team are currently producing a KHP HF patient passport booklet and reviewing other relevant resources available for heart failure patients; including cardiac devices and pregnancy. Any additional resources used will be incorporated into the appendix following approval by the trusts across KHP.

### Non-English speakers

KCH and GSTT provide ‘Language Line Support Services’ for patients in the clinical setting and provide translation if required and there is currently some collaborative work between GSTT and KCH for a joint KHP approach. For further support: GSTT has an intranet site, email address: languagesupport@gstt.nhs.uk and telephone number: 020 7188 8815

KCH has a KCH public website, email address: kch-tr.interpreting@nhs.net or tel: PALS on 020 3299 3601 for more information/questions).
Appendix 8
Information to be added to all patients discharge information for referral to the HFSN team and other teams and services

- Via the discharge summaries at GSTT
- Via the referral forms at KCH

*Suggest this is written in a ‘Word’ document first and then cut and pasted into EDL as writing directly into the EDL does not allow formatting.*

<table>
<thead>
<tr>
<th>Nursing Comment - Heart Failure Nurse Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart failure code: HFrEF □ 585f  HFrEF □ G583</td>
</tr>
<tr>
<td>Name of consultant cardiologist/care of the elderly care consultant with an interest in HF:</td>
</tr>
<tr>
<td>Signs and symptoms:</td>
</tr>
<tr>
<td>NYHA:</td>
</tr>
<tr>
<td>Last examination:</td>
</tr>
<tr>
<td>BP:</td>
</tr>
<tr>
<td>Pulse:</td>
</tr>
<tr>
<td>Weight:</td>
</tr>
<tr>
<td>Weight loss on admission:</td>
</tr>
<tr>
<td>ECG:</td>
</tr>
<tr>
<td>Bloods:</td>
</tr>
<tr>
<td>Echo:</td>
</tr>
<tr>
<td>Education issues covered (or not covered – stating reason not covered):</td>
</tr>
<tr>
<td>Management plan:</td>
</tr>
<tr>
<td>If not started on evidence based HF medication (state reason):</td>
</tr>
<tr>
<td>Any other information:</td>
</tr>
<tr>
<td>Reason for referral:</td>
</tr>
<tr>
<td>Discharged to other teams/services:</td>
</tr>
<tr>
<td>Name and designation:</td>
</tr>
</tbody>
</table>
Appendix 9
Referral Form to HFSN Community Team

Please email referral to: gst-tr.KHPcommunityHF@nhs.net

*Please be aware we are unable to accept any referrals without a complete formal/echo/MRI

*Please make sure patients with a new diagnosis of heart failure go through the pathway

*Patients with HFrEF cannot be accepted to the service unless they are under a consultant cardiologist and have a current management plan in place

<table>
<thead>
<tr>
<th>Patients Name:</th>
<th>GP Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Name:</td>
</tr>
<tr>
<td>NHS Number:</td>
<td>Address:</td>
</tr>
<tr>
<td>Address:</td>
<td>Telephone no:</td>
</tr>
<tr>
<td>Telephone no:</td>
<td>Next of kin:</td>
</tr>
<tr>
<td>Next of kin:</td>
<td>Telephone no:</td>
</tr>
<tr>
<td>Telephone no:</td>
<td>Fax:</td>
</tr>
<tr>
<td>GP Details:</td>
<td>Email:</td>
</tr>
</tbody>
</table>

**Essential information to be sent with every referral:**
- Past medical history & any discharge summary
- Latest echocardiogram/MRI & ECG
- Recent blood results (minimum of FBC & U+E)
- Recent cardiologist letter/ clinical letters
- GP summary/medication list

**Borough of Residence**
- Lambeth
- Southwark

<table>
<thead>
<tr>
<th>Has patient agreed and consented for referral?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any safety &amp; access issues for domiciliary visit?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Advocate required:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation Status (if available):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Diagnosis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>LVSD</td>
</tr>
<tr>
<td>Non-LVSD: HFrEF / Diastolic HF</td>
</tr>
</tbody>
</table>

**Reason for referral:**
- Patient symptomatic despite maximum tolerated medication
- Medication titration of complex patients (e.g. hypotension, significant renal dysfunction)
- Patient and/or carer needs support with education and self-management

Weight on referral: ..........kg
Weight on discharge (if applicable): ..........kg

<table>
<thead>
<tr>
<th>Referrer's name &amp; title:</th>
<th>Contact Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accept Referal</td>
<td>*Referral Inappropriate (specify why)</td>
</tr>
</tbody>
</table>

*If patient referred is ineligible for the service send an email to the referrer outlining reason (content of email is outlined in Appendix 12)*
Appendix 10
Referral process from consultant cardiology out-patient clinics to community HFSNs and out-patient HFSN clinics

<table>
<thead>
<tr>
<th><strong>GSTT</strong></th>
<th>Consultant cardiologist required to email <a href="mailto:HeartFailureNurses@gstt.nhs.uk">HeartFailureNurses@gstt.nhs.uk</a></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KCH</strong></td>
<td>Consultant cardiologist copies acute HFSN into clinic letter via email to <a href="mailto:gsttrkhpcommunity@nhs.net">gsttrkhpcommunity@nhs.net</a></td>
</tr>
</tbody>
</table>

The email letter should specify:

- ✓ Reason for referral
- ✓ HFSN will triage if community clinic, home visit or GSTT or KCH acute HFSN clinic required
- ✓ Echo report
- ✓ Recent bloods
- ✓ A management plan (essential for HFpEF patients)

The consultant cardiologist where possible should issue the first prescription in clinic for any medication changes as there can be considerable delays in the community for GPs to make changes.

HFSN will send an acknowledgement that the referral has been received

*GSTT and KCH consultants should send a follow up letter to the HFSN*
Appendix 11
Referral process to the HFSN service for patients with heart failure preserved ejection fraction (HFpEF)

Patients with HFpEF

- Previously known to the HFSN service or under the care of a consultant cardiologist/elderly care consultant with an interest in HF
  - Accept Referral
    - Discuss with the consultant cardiologist or care of the elderly consultant at the MDT meeting and agree a management plan

- Not known to the HFSN service not under the care of a consultant cardiologist/elderly care consultant with an interest in HF
  - Decline Referral
    - ✓ Email GP to inform that prior to referral the patient must be initially assessed by a consultant cardiologist or care of the elderly consultant with an interest in HF
    - ✓ If the patient is appropriate for the HFSN service a clear management plan must be in place
Appendix 12
Patient ineligible for HFSN Community Service
Content of email to be sent to referrer (if not GP, cc GP in)

Dear.............................................................................................................

Thank you for your referral, unfortunately your patient does not meet the eligibility criteria for the Heart Failure Specialist Nurse Community Service as outlined below:

<table>
<thead>
<tr>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No formal copy of the echocardiogram/MRI report</td>
</tr>
<tr>
<td>□ Patients with HF with preserved ejection fraction (HFrEF) not under the care of a consultant cardiologist/ care of the elderly consultant with an interest in HF must be referred in the first instance to a consultant cardiologist. They will review and refer the patient with a management plan directly to the community HF nurse as appropriate</td>
</tr>
<tr>
<td>□ Patients with valvular disease who have not been assessed by a consultant cardiologist for valvular intervention</td>
</tr>
<tr>
<td>□ Patients registered with a GP outside Southwark and Lambeth</td>
</tr>
<tr>
<td>□ Patients who decline the support of the service</td>
</tr>
<tr>
<td>□ Other immediately life threatening illness, for example, advanced malignancy</td>
</tr>
<tr>
<td>□ End stage renal disease (CKD V eGFR&lt;15)</td>
</tr>
<tr>
<td>□ CKD 1V at discretion of cardiologist and renal team eGFR&gt;15 (must have a management plan)</td>
</tr>
<tr>
<td>□ Immediately post-MI unless the patient has previously had the support of the service (or if the ejection fraction is ≤30%)</td>
</tr>
</tbody>
</table>

For further information do not hesitate to contact us.

Yours sincerely

Community Heart Failure Specialist Nurse Team
Appendix 13
Follow-up triage by HFSN

This system is to be used as a standard in which the HFSN team will triage patients who have been referred with a confirmed diagnosis on echocardiogram/MRI with a formal report included.

Patients admitted to hospital for heart failure must be seen within 10 working days of discharge

Referral Category

High/Red
- Discharged from hospital, admission for HF
- Referred by another source with unstable symptoms
- Phone within 2 working days
- Aim to see within 5 working days
- Must be seen within 10 working days

Medium/Amar
- Discharged from hospital non HF admission
- Referred by another source with changing symptoms
- Phone within 2 working days
- Aim to see within 10-15 working days depending on telephone assessment

Low/Green
- All other referrals with stable symptoms
- Phone within 2 working days
- Contact details given with advice on self management and when to contact
- Appointment given at discretion of HFSN within 10 weeks

Contact details given with advice on self management and when to contact
Appendix 14
Patient declined support of the HFSN service template letter
Send to referrer (if not GP, cc GP)

Date:                                                                                                                 Address:

Patient name:                          Date of Birth:                           NHS number:

Address:

Dear………………………………

Your patient was referred to the heart failure specialist nursing team but has declined to have the support of the team. We have advised the patient to:

- Continue taking the medication prescribed and to obtain further supplies from their GP
- Ensure that they have blood tests, and their blood pressure and pulse checked by their GP at least every six months
- Continue to monitor their weight regularly and seek medical advice if their weight increase rapidly or notice that their ankles are swelling or if they are more breathless than usual
- Take their current medications and weight monitoring charts with them if they become unwell and need to attend A&E.

If you feel we can be of support in the future and the patient wishes to engage with the service please do not hesitate to refer again.

Yours sincerely

Heart Failure Specialist Nurse Team

Cc GP
Appendix 15
Criteria for home visit by Heart Failure Specialist Nurse Team

Only housebound patients will be seen in their own homes. Those that do not fulfil this criteria will be seen in a local or out-patient clinic convenient to them.

A housebound patient is a person who:

- has a physical or psychological condition with documented evidence which states that it would be detrimental to their condition or recovery to travel
- requires assistance from more than one person to get in and of a vehicle OR
- needs medical/clinical support during the journey OR
- is wheelchair bound and has no carer available to assist them OR
- is bedbound

Patients who do not meet the criteria:

- able to go to GP/hospital or community clinics
- able to be taken out by family members or carers are able to visit family members
- able to drive or use taxi services
- able to get in a vehicle independently or use public transport services e.g. bus, train

An individual will not be eligible for a home visit if they are able to leave their home on their own or with minimal assistance to visit public or social/recreational services or can go shopping or go to the hairdressers etc.

In certain circumstances Trust transport can be offered.
Appendix 16a
GP Follow up letter

Heart Failure Team

All letters will be generated through EPR and will therefore be on Trust headed paper with autocompleted patient demographics and G.P. details on selection of the correct patient.

The long term conditions template front sheet will be used for all heart failure specialist nursing service letters and the following information fields will completed at the beginning of all G.P. letters.

Front Page

The above patient was reviewed today. Please find enclosed a summary of assessment, examination and recommendations.

<table>
<thead>
<tr>
<th>Actions for GP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HF code (select):</strong></td>
<td></td>
</tr>
<tr>
<td>585F (LVSD on echo)</td>
<td>□</td>
</tr>
<tr>
<td>GS83 (all other non-LVSD)</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actions for patient:</th>
<th>Patient stated / agreed goals</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient agreed actions towards goals</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Action for HF specialist team:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Prevention of admission:</th>
<th>Y/N</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Follow up appointment:</th>
<th>Date / Number of weeks</th>
</tr>
</thead>
</table>
Appendix 16b
Subsequent pages of GP Follow-up letter from HFSN team

It is acknowledged that there will be differences in format and appearance of letters between KCH and GSTT HFSN services, however a minimum data set should be included in each letter sent from the HFSN team. The patient’s primary concern should be clarified at each clinic/home visit and the letter should reflect the keys issues explored within the consultation.

All letters should include:

✓ Specific heart failure aetiology i.e. Ischaemic, Non-ischaemic etc.
✓ Past Medical history
✓ Current medication (if patient is taking a long time to be optimised on HF medications document reason)
✓ Allergies / intolerances
✓ Adherence assessment
✓ Echo / MRI
✓ ECG / 24 hr ECG / Pacing / CRT-D/P / ICD check

✓ Social history
  - home situation
  - carers
  - occupation or former occupation
  - smoking history and whether cessation has been offered / taken up
  - alcohol history and whether signposted for harm reduction where appropriate
  - whether signposted for benefits entitlement / disability support
  - mental health assessment – scores for PHQ9, GAD 7 at new appointment and repeated as necessary
  - quality of life assessment – Minnesota Score at new appointment, 6 months and discharge from service

✓ Signs and symptoms assessment
  - breathlessness assessment
  - exercise tolerance – including whether able to manage stairs, slopes, hills
  - chest pain, palpitations, dizziness, falls, loss of consciousness
  - fluid intake and appetite / nutrition
  - NYHA Class

✓ Examination
  - sitting/lying and standing blood pressure
  - pulse – stating regular or irregular
  - weight – stating whether increased or decreased JVP
  - assessment of oedema/chest auscultation
  - any additional findings from examination

✓ Relevant blood results and trend
✓ Patient Education and advice
✓ Whether advanced care planning indicated and preferred place of care
✓ Referrals made as a result of the clinic review
✓ Contact details of the heart failure team and when to contact
Appendix 17
Unable to contact patient template letter

Date: Address:

Patient name: Date of Birth: NHS number:

Address:

Dear ……………………………………………

Your patient was referred to the heart failure specialist nursing team for support and management of their condition. Unfortunately, we have been unable to contact them on two occasions to arrange an appointment.

We have written to the patient and advised them to:

- Continue taking the medication prescribed and obtain further supplies from their GP
- Have a blood test and their blood pressure and pulse checked by their GP at least every six months
- Continue to monitor their weight regularly and seek medical advice if their weight increases rapidly, or notice that their ankles are swelling or if they are more breathless than usual
- Take their current medications and weight monitoring charts if they become unwell and need to attend A&E.

If you feel we can be of support in the future and the patient wishes to engage with the service please do not hesitate to refer again.

Yours sincerely

Heart Failure Specialist Nurse Team

Cc: GP
Cc: Cardiologist
Appendix 18
Patient did not attend template letter

Date:

Address:

Patient name:                          Date of Birth:                           NHS number:

Address:

Dear……………………………………

We hope that you are well. Unfortunately we have not seen you at your last two heart failure clinic appointments. You may have forgotten about these appointments or it may not have been convenient for you to attend.

In the meantime in order to remain well, it is very important that you:

- Continue taking the medication that you have been prescribed, obtaining further supplies from your GP
- Ensure that you have a blood test, and your blood pressure and pulse checked by your GP at least every six months
- Continue to monitor your weight regularly and seek medical advice early or call us should your weight increase rapidly
- Call us on…………………….. or your GP if you notice that your ankles are swelling or if you are more breathless than usual

If you are very unwell and need to attend A&E, please take your current medications and your weight monitoring charts.

We do not intend sending further heart failure clinic appointments to you at present unless your GP requests one. However it is very important that you are followed up on a regular basis. We will be very happy to send you an appointment if your GP requests this and you are in agreement to attend.

Yours sincerely

Heart Failure Specialist Nurse Team

Cc: GP
Cc: Cardiologist
Appendix 19
GP template letter patient discharged from HFSN service

Date:
Address:

Patient name: Date of Birth: NHS number:
Address:

Heart failure code: HFrEF 585f □ HFpEF G583 □

Dear Dr ..........................................................

Your patient has been under the care of the Heart Failure Specialist Nurse Service since ....... We are now discharging them back to your care as they are on optimal tolerated dose of evidence based heart failure therapies and are symptomatically stable.

Reason for sub-optimal dose or exclusion (if applicable):

<table>
<thead>
<tr>
<th>Drug</th>
<th>Hypotension</th>
<th>Renal dysfunction</th>
<th>Bradycardia</th>
<th>Other</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE Inhibitor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beta blocker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sacubitril/valsartan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient attended cardiac rehabilitation:
Y □ N □ (specify why patient did not attend)........................................................................

As per NICE quality standards for heart failure, please ensure xxxxxx is reviewed every 6 months. This should include a review of medication (including need for changes and possible side effects) and blood tests - serum urea, electrolytes, creatinine, eGFR and full blood count.

Please do not hesitate to re-refer if there is any significant deterioration in their symptoms or if you need any further advice. I have also advised the patient that they can self refer back to the service if their condition deteriorates.

Yours sincerely

Heart Failure Specialist Nurse Team

Cc GP
Cc Heart failure community pharmacist
Appendix 20

MINNESOTA LIVING WITH HEART FAILURE® QUESTIONNAIRE

The following questions ask how much your heart failure (heart condition) affected your life during the past month (4 weeks). After each question, circle the 0, 1, 2, 3, 4 or 5 to show how much your life was affected. If a question does not apply to you, circle the 0 after that question.

<table>
<thead>
<tr>
<th>Did your heart failure prevent you from living as you wanted during the past month (4 weeks) by -</th>
<th>No</th>
<th>Very Little</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. causing swelling in your ankles or legs?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. making you sit or lie down to rest during the day?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. making your walking about or climbing stairs difficult?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. making your working around the house or yard difficult?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. making your going places away from home difficult?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. making your sleeping well at night difficult?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. making your relating to or doing things with your friends or family difficult?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8. making your working to earn a living difficult?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9. making your recreational pastimes, sports or hobbies difficult?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10. making your sexual activities difficult?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11. making you eat less of the foods you like?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>12. making you short of breath?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13. making you tired, fatigued, or low on energy?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>14. making you stay in a hospital?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15. costing you money for medical care?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>16. giving you side effects from treatments?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>17. making you feel you are a burden to your family or friends?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>18. making you feel a loss of self-control in your life?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>19. making you worry?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>20. making it difficult for you to concentrate or remember things?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>21. making you feel depressed?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
### Appendix 21
The GAD-7 (Generalised Anxiety Disorder Scale) Questionnaire

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
# Appendix 22

**Patient Health Questionnaire-9 (PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use ✓ to indicate your answer)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so foggy or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

For office coding: __________ + __________ + __________ + __________ = Total Score: __________

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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