Enhanced Community Care

THE IMPACT OF NURSE-LED INTEGRATED HEART FAILURE SERVICE IN CHO 7

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Background:

Heart Failure (HF) continues to be associated with frequent readmissions, prolonged length of stay, increased morbidity and mortality. Early recognition of signs and symptoms and diagnosis of HF in the community can help reverse this pathway by early initiation of evidence based HF management however access to vital diagnostic tests and specialist nurse-led heart failure services were traditionally unavailable to General Practitioners (GPs) in the community.

Previous referral pathways for GP's to access specialist HF services in Tallaght University Hospital (TUH) often took up to 24 months or an emergency hospital admission. A Sláintecare Integrated Care Heart Failure Service initiative established in 2020 has provided direct access to an ANP-led community based Heart Failure Service in the TUH catchment area, providing access to diagnostic ECHO, NT-pro BNP testing for early diagnosis of heart failure.

This project was initiated at the beginning of the COVID-19 pandemic, this enhanced the invaluable collaboration with Community Intervention teams, GPs, Practice Nurses, Pharmacists and Public Health Nurses which contributed significantly to its success.

Aim:

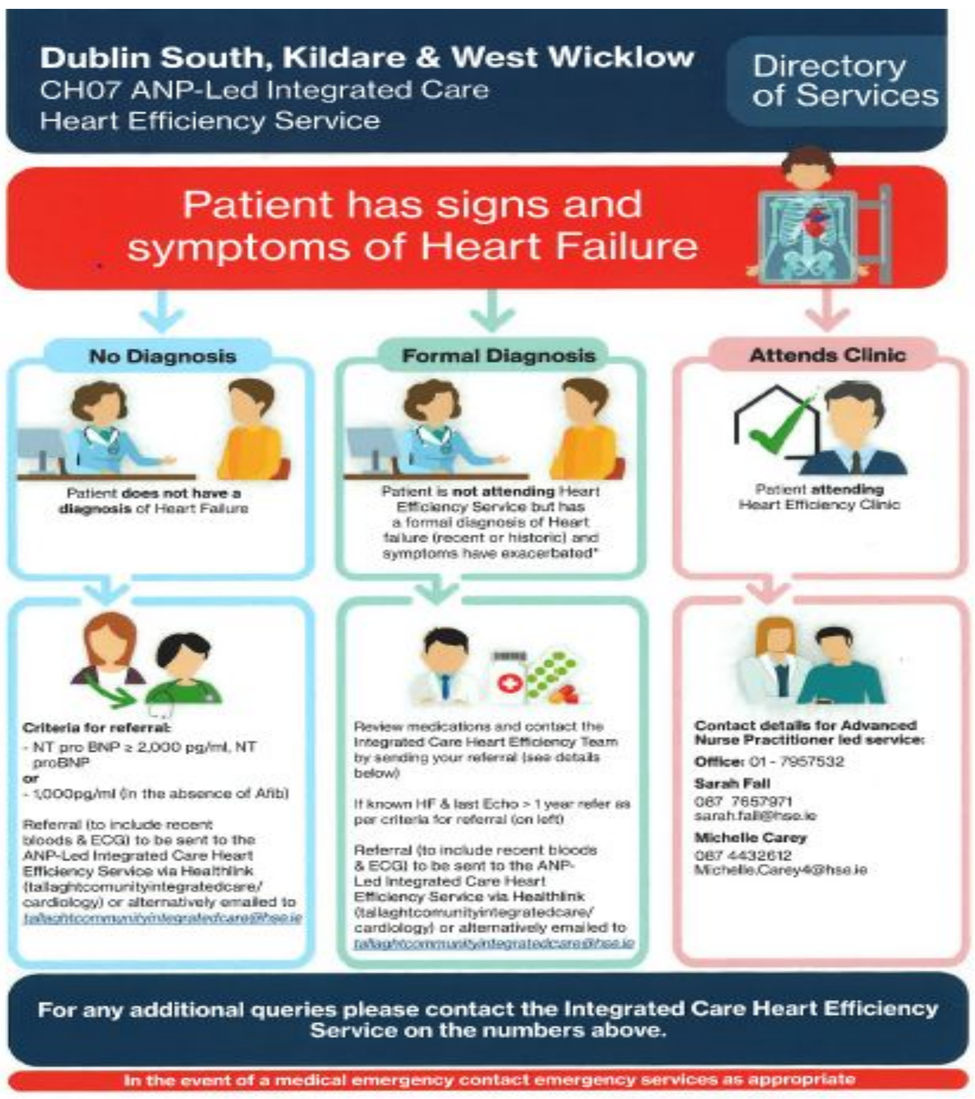
To review the impact of providing GPs with direct access to diagnostic NT-pro BNP, Echocardiography and clinical evaluation for patients demonstrating early signs and symptoms typical of HF in an ANP-led Integrated Care Heart Failure Service

Objective:

Recognising the difficulty that local GPs were having in accessing vital specialist and diagnostic services for patients exhibiting early signs and symptoms of HF, the objective of this initiative was to provide an appointment within 4 weeks of receipt of referral. Higher risk patients offered an appointment within 48 hours.

Methods:

A retrospective audit and cohort analysis was carried out on all patients referred to the Integrated Care Heart Failure Service between 01/01/2020 and 31/12/2022.



Results:

- Average time to first review 22.7 days with a median time to first review of 17 days. (Traditional OPD pathway 18-24 months).
- High risk patients were seen within 48-72 hours of receipt referral.
- 80% of patients referred were discharged back to GP.
- 20% of referrals required care escalated for Cardiologist review in TUH.

Summary	
No of pts referred by GPs	315
Male	42%
Female	58%
Mean age	71.6
Average time to first review	22.7 days
Median time to first review	17 days
High risk patients post triage of appropriate referral	48-72 hours.
Discharged back to GP	80%
Care escalated to Cardiology Consultant in TUH	20%

Conclusion:

This audit demonstrated that the majority of patients referred to the service with signs and symptoms typical of heart failure were ultimately diagnosed with overall good left ventricular systolic function.

Minor elevations in NT-pro BNP levels were mainly deemed stable due to presence of atrial fibrillation or renal dysfunction. 80% of patients were safely discharged back to the care of their GP with 20% requiring care escalated to a Cardiology Consultant in TUH.

Integration of heart failure services in the community setting led by Heart Failure Advanced Nurse Practitioners can provide a safe and swift response for patients who are demonstrating early signs and symptoms typical of heart failure. The findings of this study will help to inform the roll out of the Enhanced Community Care hubs nationwide.

Adaptation of referral criteria will be needed in order to capture the true HF patients in the community.