

Clinical Guidance for the Diagnosis and Management of Heart Failure Lincolnshire 2015

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Lincolnshire Community Health Services

Clinical Guidance for the Diagnosis and Management of Heart Failure - Lincolnshire V8 - 2015-17

Version Control Sheet

Version	Section/Para/ Appendix	Version/Description of Amendments	Date	Author/Amended by
1	P35	Change to advice on metoclopramide and domperidone use	071014	jscrafton
2	P41	Addition of advice to consider renal and liver function before prescribing and renal last days information link file	May 2015	jscrafton
3	all	LCHS info updated	MAY 2015	jscrafton
4	Titles	Updated to 2015-17 Chair of LCHS info updated. Removal of hospital pathway document as is not in use.	May 2015	jscrafton
5	all	All weblinks and document links updated	May 2015	jscrafton
6	46	Deactivation advice	Aug 2015	agladwin
7	29	New BTS oxygen guidelines added	Aug 2015	jscrafton
8	10	Algorithm altered to reduce risk of inappropriate use of MRA/AA and to reflect NICE TA 314 CRT/ICD guidance 2014	Aug 2015	jscrafton
	12	Altered to say "low dose spironolactone/ eplerenone max. 25mg		
	19	Altered to "avoid if eGFR/ EPI <30)		
	20	CRT guidance updated		
	27	Liverpool Care Pathway removed – refer to agreed local/national care of dying adult guidance		
	22	Addition of sick day rules / frailty advice		

	52	Quick Guide to aid clinicians to know when to refer for specialist heart failure review		
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Lincolnshire Community Health Services

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Contents

- i) Version Control Sheet
- ii) Policy Statement

SECTION	PAGE
1 Summary of the purpose of the guidance	6
2 Indications for the use of the guidance	6
3 Associated Policies/Guidance	6
4a Clinical Guidelines and Pathways Index	7-8
4b Clinical Guidelines and Pathways	9-49
5 Useful Weblinks/Contacts	50
6 References	51
7 Audit/Monitoring of policy implementation	56
8 Implementations Strategy	56
9 Equality Analysis	57

Lincolnshire Community Health Services

Clinical guidance for the management of patients with confirmed Heart Failure in primary care in Lincolnshire

Guideline Statement

Background:	This Clinical guidance provides pathways for ensuring robust diagnosis and treatment of heart failure using best available evidence at time of writing.
Statement:	The guidance outlines a series of algorithms to support the management of patients with suspected heart failure and diagnosed heart failure.
Responsibilities	Community Heart Failure Nurses working for LCHS are responsible for updating guidelines every 2 years in collaboration with ULHT, St Barnabas Hospice, PACEF and Medicines Management Committee.
Training	The heart failure Complex Case Managers deliver education regarding the management of patients with chronic heart failure which is based on the guidance.
Dissemination:	This guidance will be on the LCHS Trust website
Resource implication:	The clinical guidance will be further reviewed Bi-annually and amended in light of the latest NICE guidance

Summary of the purpose of the Guidance

The purpose of this document is to provide guidance and a pathway for the treatment of patients with heart failure. The guidance is separated into two parts; the first addresses best practice in the clinical management of heart failure itself and the second focuses on management of symptoms commonly experienced in advanced heart failure and is concerned with palliative and supportive care.

The guidance takes the form of a series of algorithms supporting the optimal pharmacological and non pharmacological management including appropriate referral pathways to specialist heart failure services.

Terms:

The term Specialist Heart Failure Multidisciplinary team (HFMDT) will be used throughout the guidelines. The MDT comprises of Cardiologists, Heart Failure Complex Case Manager (HFCCM) or Heart Failure Clinical Nurse Specialist (HFCNS) and General Practitioner with a Special Interest in heart failure (GPSI).

The term Advanced Heart Failure MDT is used; this is a monthly meeting comprising of members of the Specialist Heart Failure MDT and other healthcare professionals involved in the care of heart failure patients including St Barnabas Hospice, Macmillan Specialist Nurses and Discharge Community Link Nurses; Palliative Care.

The role of HFCCM or HFCNS is a specialist nursing role incorporating complex case management, clinical assessment, diagnosis, non-medical prescribing and management of patients with chronic heart failure. The role meets the educational standards as set out by the British Heart Foundation.

Indications for the use of the Clinical Guidance

The algorithms should be used in conjunction with the associated national standards and NICE guidance in order to support the stabilisation of a patient's heart condition through optimising treatment, providing support and where necessary palliative care.

Associated Policies/ Guidance

Department of Health (2000), Heart Failure, Chapter Six, National Services Framework for Coronary Heart disease

British National Formulary (2015) accessed at www.BHF.org [online] Lincoln, June & Aug 2015

National Institute for Health and clinical Excellence (2010) Chronic Heart Failure, Management of Chronic heart failure in adults in primary and secondary care.

European Society of Cardiology (ESC) Guidelines for the diagnosis and treatment of acute and chronic heart failure (2012) available at www.escardio.org

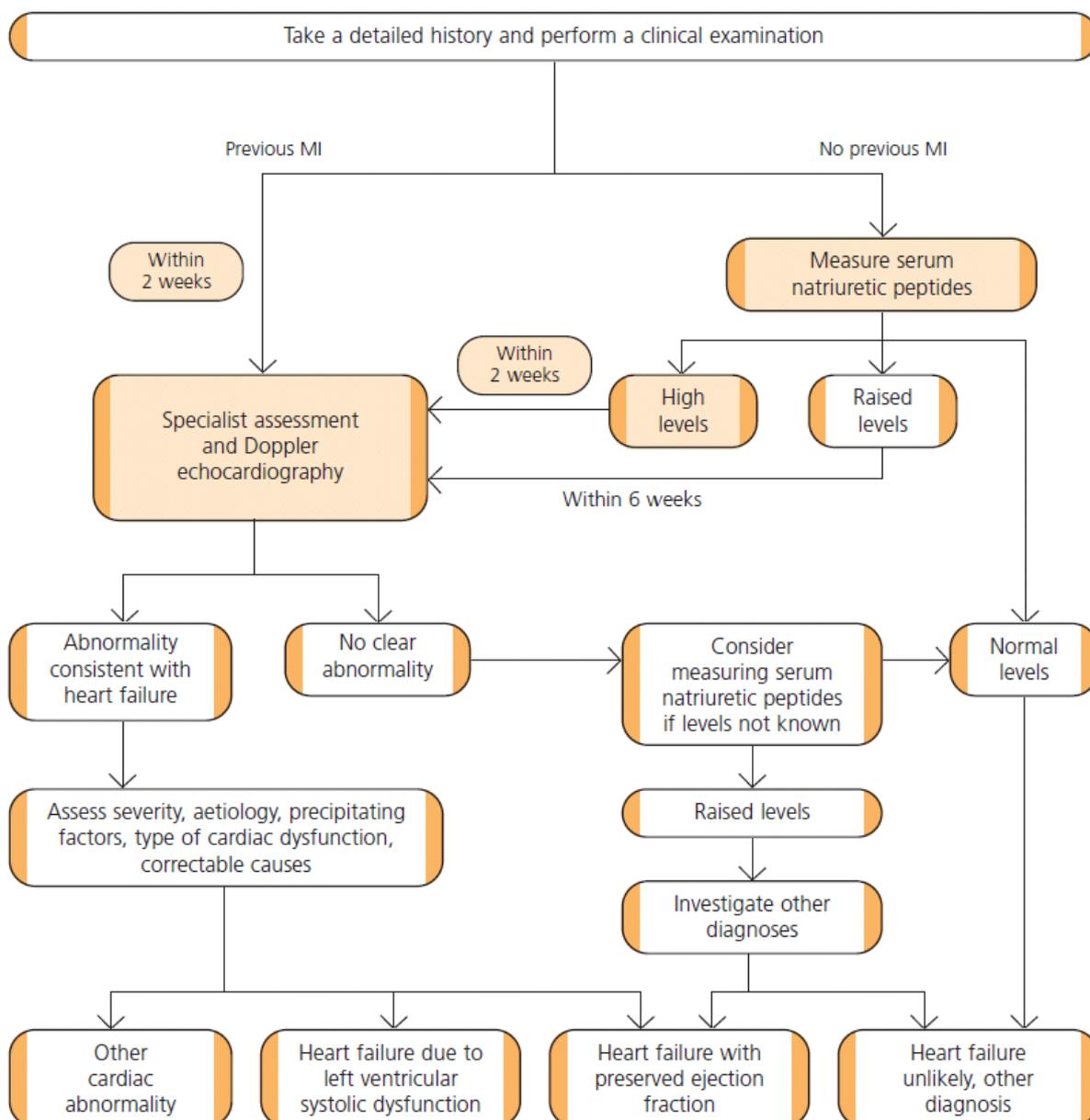
NICE TA134 June (2014) accessed at <https://www.nice.org.uk/guidance/ta314/chapter/1-Guidance> [online] Lincoln, 19th August 2015

Guidelines and Pathways Index

Diagnosing Heart Failure including use of Serum Natriuretic Peptides.....	9
Algorithm for Treating Heart Failure.....	10
Pathway for Management of Heart Failure in Community.....	11
Pharmacological Management of Heart Failure	12-21
Algorithm for the introduction of Angiotensin Converting Enzyme Inhibitors (ACEI) or Angiotensin Receptor Blocker (ARB), if intolerant of ACEI.....	12
Algorithm for use of Beta blockers in Heart Failure.....	13
Algorithm for the use of angiotensin receptor antagonists (ARB) in Heart Failure.....	13
Algorithm for the use of Hydralazine and Nitrate Combination in Heart Failure.....	144
Algorithm for the use of Loop Diuretics for Confirmed Heart Failure.....	155
Algorithm for the use of Aldosterone Antagonists and Mineralocorticoid Receptor Antagonists in Heart Failure.....	16
Algorithm for the use of Combination Diuretic (Specialist Initiation and Monitoring).....	17
Algorithm for the use of Ivabradine in Heart Failure (Specialist Initiation).....	18
Management of Arrhythmias	
Atrial Fibrillation.....	18
Consideration of Anticoagulation for People with Heart Failure.....	19
Algorithm for the use of cardiac synchronisation (CRT) therapy &/or internal cardioverter defibrillators (ICD), or both (CRT-D) Based on NICE technology appraisal guidance 314.....	20
Non Pharmacological Management for ‘Confirmed’ Heart Failure in Primary Care.....	211
Sick Day Rules and Managing Heart Failure in Frail Older People.....	22
Management of symptoms commonly experienced in Advanced Heart Failure.....	22-46
Guidance as to when a Heart Failure Patient becomes “Palliative”.....	24
Issues for consideration when assessing patient’s needs	25
Diagnosis and prognosis.....	25
Preferred Priorities of Care.....	25
Management Planning and Anticipatory Prescribing.....	26
Carer Support.....	26
Palliative Care Heart Failure: Guidance on Care Package Considerations.....	27
Management of Suspected Acute Confusion / Delirium.....	28
Management of Breathlessness.....	299
Management of constipation.....	30
Management of Cough.....	31
Management of Fatigue.....	32

Management of Itching / Pruritis.....	33
Special Issues for Consideration when Managing Pain in Heart Failure.....	34
Management of Nausea and Vomiting.....	35
Management of Peripheral Oedema.....	36
Management of Poor Appetite and Weight Loss/ Cachexia.....	37
Psychological Concerns.....	38
Management of Sleep Disturbance and Insomnia.....	38
Management of Stomatitis / Sore Mouth.....	40
Medicines Management in Advanced Heart Failure incl end of life with renal impairment guide.....	41
Management of Anaemia.....	42
Management of Gout.....	42
Pathway for Decision Making and Advance Care Planning - Chronic Heart Failure.....	44
Iatrogenic Problems.....	45
Drugs to Avoid in Heart Failure.....	45
Pathway for Deactivation of Implantable Cardioverter Defibrillators at End of Life.....	46
Community Heart Failure Complex Case Manager Service.....	47
Appendix One:Community Heart Failure Complex Case Manager Referral Form.....	488
Appendix Two Request for Deactivation on Implantable Cardioverter Defibrillator.....	50
Appendix Three: Patient Self Monitoring and Management Prompt	51
Appendix Four: A Quick Guide to Heart Failure Management for Lincolnshire.....	52
Useful Weblinks/ contacts.....	53
References.....	54
Audit/ Monitoring of policy Implementation.....	59
Implementation Strategy.....	59
Equality Analysis.....	60

Diagnosing heart failure



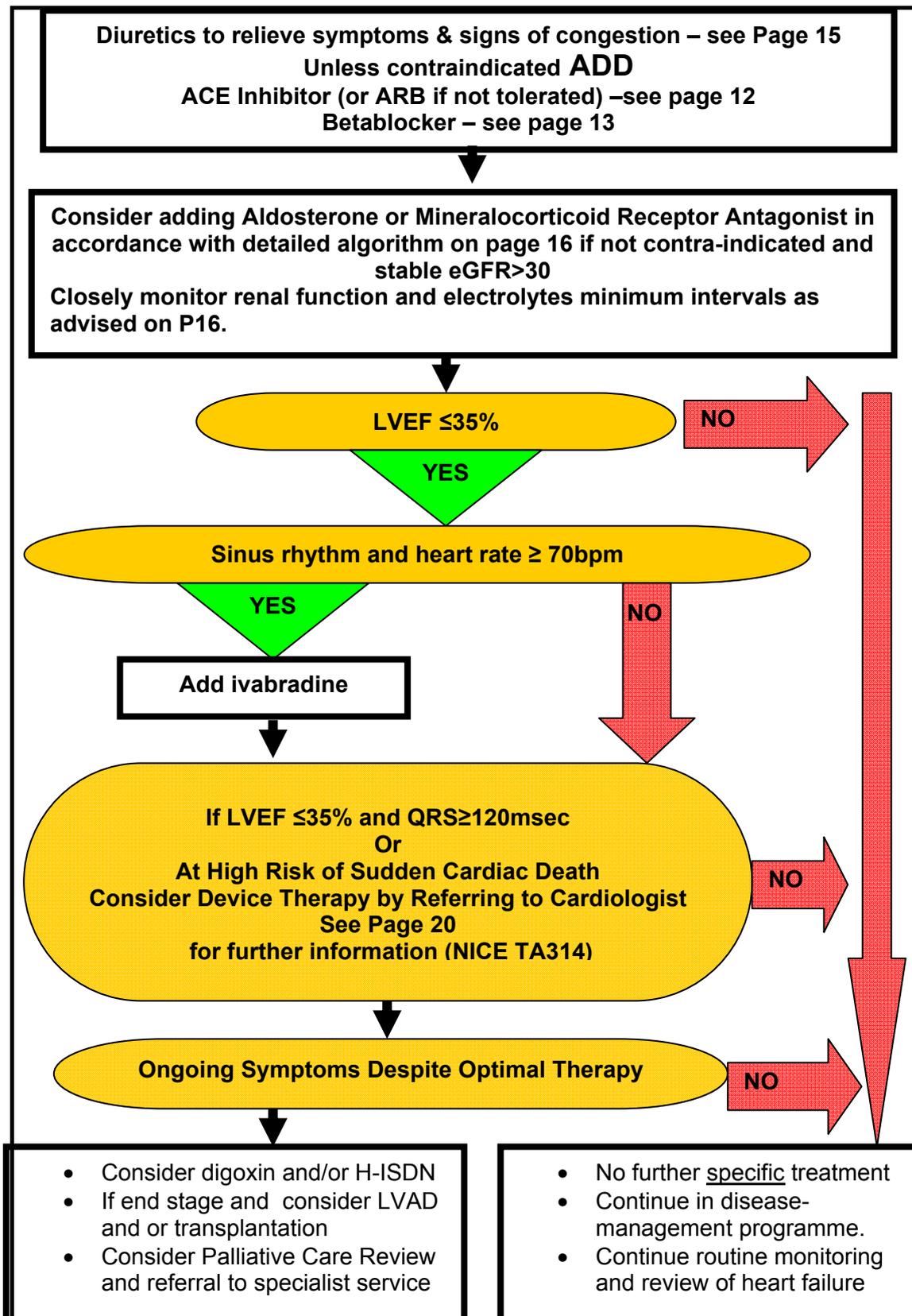
Diagnosing Heart Failure including use of Serum Natriuretic Peptides

- High levels – BNP > 400 pg/ml (116 pmol/litre) or NTproBNP >2000 pg/ml (236 pmol/litre)
- Raised levels – BNP 100–400 pg/ml (29–116 pmol/litre) or NTproBNP 400–2000 pg/ml (47–236 pmol/litre)
- Normal levels – BNP < 100 pg/ml (29 pmol/litre) or NTproBNP < 400 pg/ml (47 pmol/litre)

Be aware that:

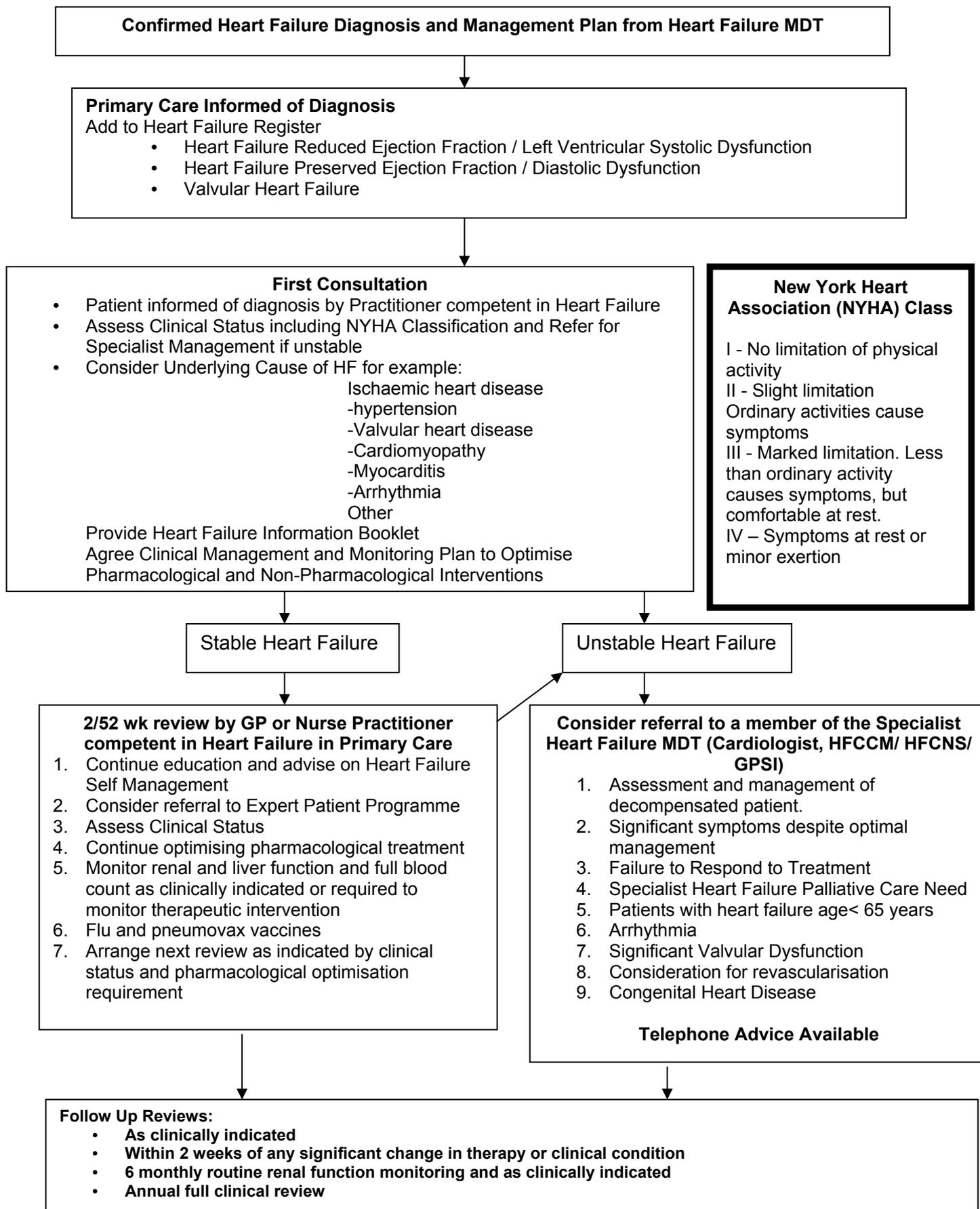
- obesity or treatment with diuretics, angiotensin-converting enzyme (ACE) inhibitors, beta-blockers, angiotensin II receptor antagonists (ARBs) and aldosterone antagonists can reduce levels of serum natriuretic peptides
- high levels of serum natriuretic peptides can have a cause other than heart failure (for example, left ventricular hypertrophy, ischaemia, tachycardia, right ventricular overload, hypoxaemia [including pulmonary embolism], renal dysfunction [GFR < 60 ml/minute], sepsis, chronic obstructive pulmonary disease [COPD], diabetes, age > 70 years and cirrhosis of the liver).

Algorithm for Treating Heart Failure

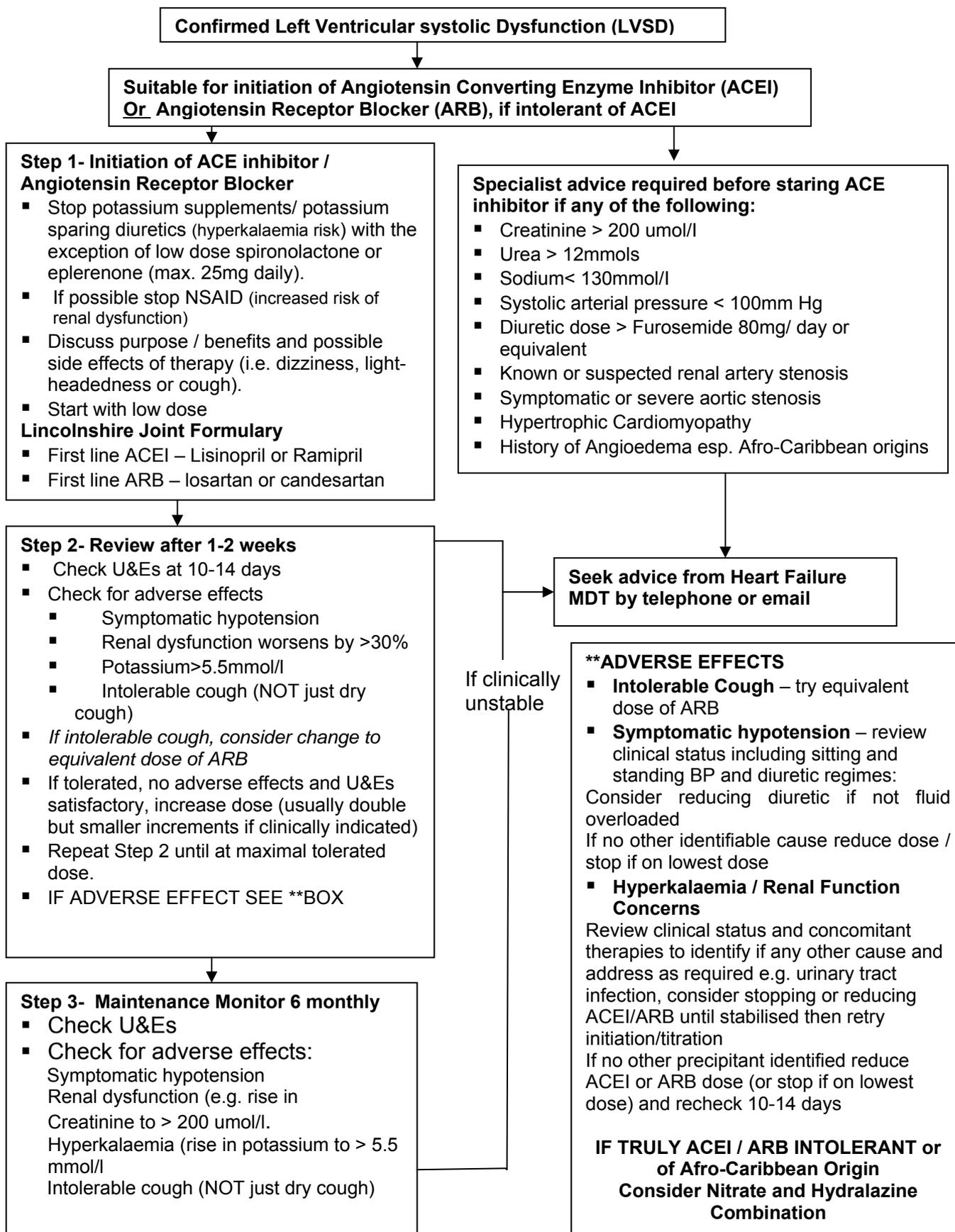


Adapted from European Society of Cardiology Management of Heart Failure 2012
www.escardio.org

Pathway for Management of Heart Failure in Community

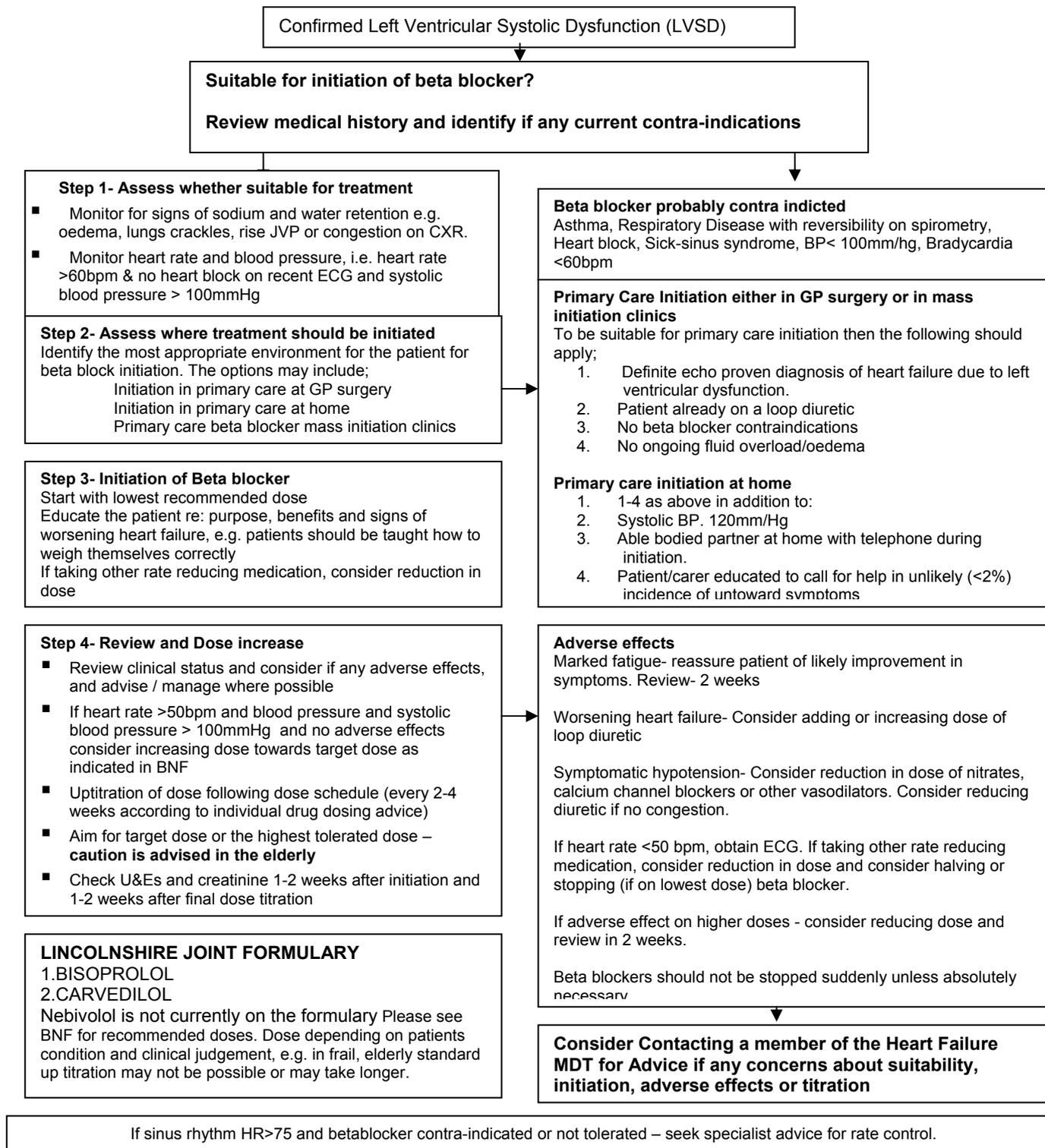


Algorithm for the introduction of Angiotensin Converting Enzyme Inhibitors (ACEI) or Angiotensin Receptor Blocker (ARB), if intolerant of ACEI



NB: CHOICE OF ACE INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER SHOULD TAKE INTO ACCOUNT LINCOLNSHIRE JOINT FORMULARY RECOMMENDATIONS

Algorithm for use of Beta blockers in Heart Failure

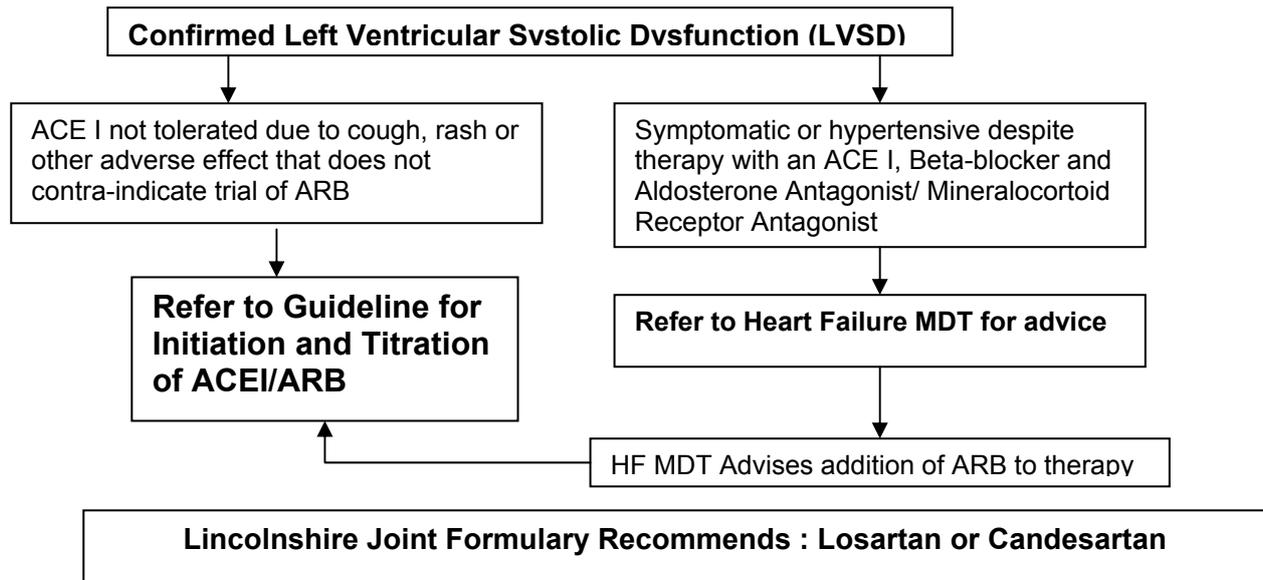


Which Betablocker?

Bisoprolol - Stable chronic moderate to severe heart failure (NYHA II-IV) with reduced ventricular function in addition to standard therapy. More cardioselective than carvedilol, therefore may be choice when co-morbid respiratory disease. Once daily dose, hepatic and renal excretion.

Carvedilol Indications- Stable mild to moderate chronic heart failure (NYHA I-III) in addition to standard therapy, additional antioxidant effect . Twice daily dose, mainly hepatic excretion, lipophilic - can be useful if having vivid dreams problematic on other betablockers

Nebivolol- May be considered in light of the seniors trial in patient over the age of 70 and Left Ventricular Ejection Fraction < 35%, most cardioselective and may be useful in those with peripheral vascular disease

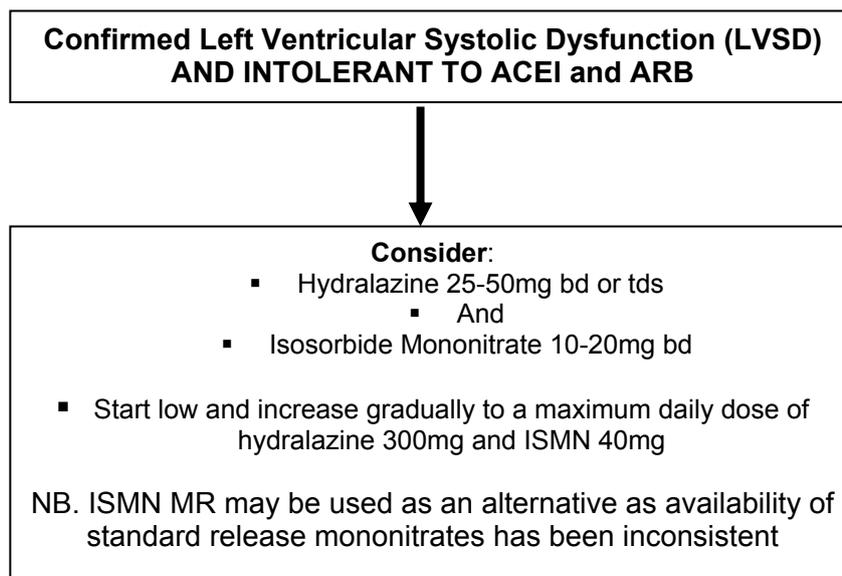


Management of Hypertension

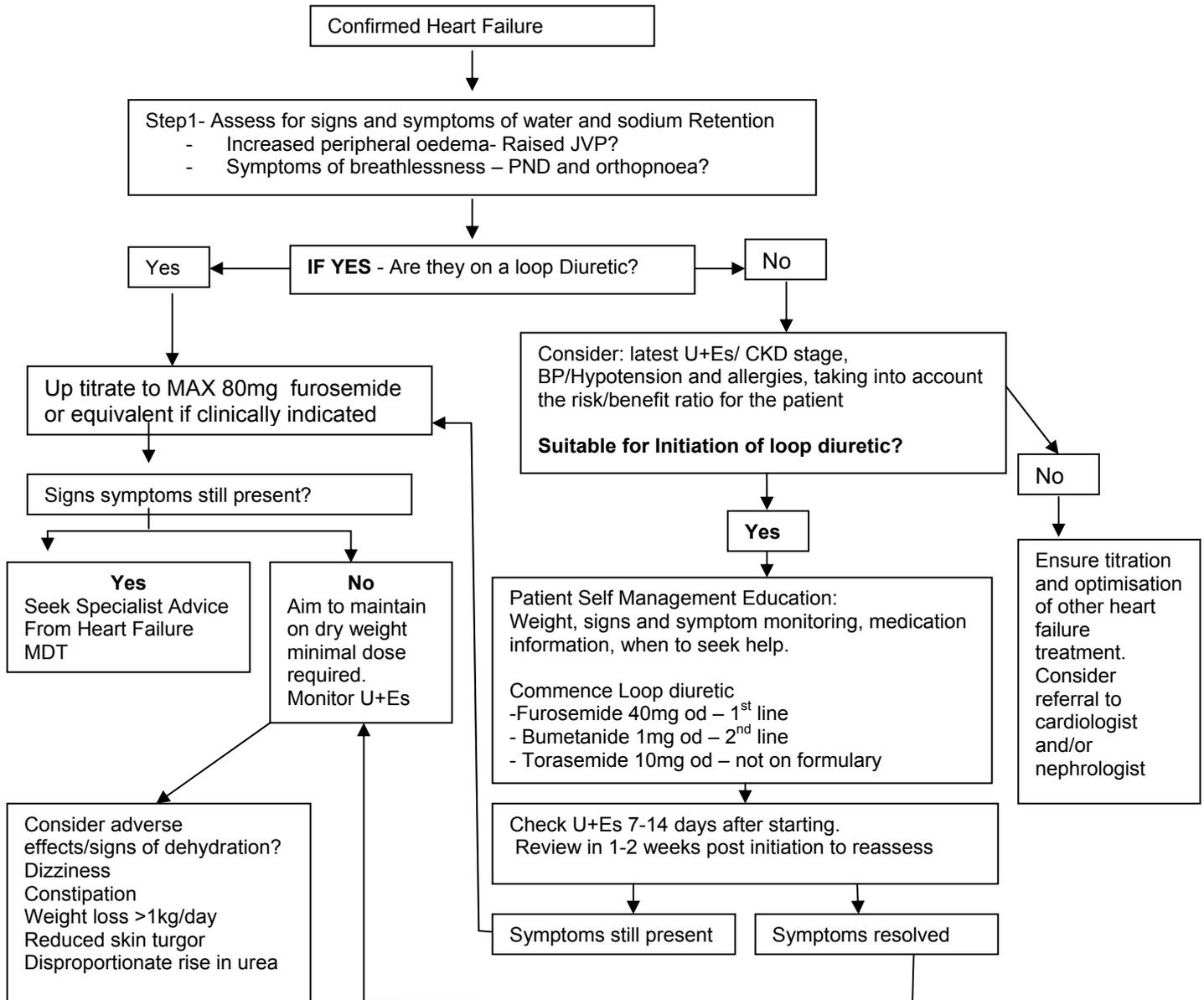
<http://www.nice.org.uk/guidance/CG127>

www.bhsoc.org

Algorithm for the use of Hydralazine and Nitrate Combination in Heart Failure



Algorithm for the use of Loop Diuretics for Confirmed Heart Failure



NB: Diuretics should administered in combination with ACE inhibitors ARBs and B- blockers if tolerated

Choice of Diuretic:
Lincolnshire Joint Formulary recommends:
First line Furosemide
Second line Bumetanide

Bumetanide has greater bioavailability and should be substituted if furosemide not effective or not tolerated

Algorithm for the use of Aldosterone Antagonists and Mineralocorticoid Receptor Antagonists in Heart Failure

Confirmed Left Ventricular Systolic Dysfunction (LVSD)

Severe Heart Failure with EF≤35% - Spironolactone
 Post Acute Myocardial Infarction and LVEF≤40% - Eplerenone
 Mild Heart Failure and EF≤30% or EF≤35% and QRS Duration>130msec – Eplerenone
Lincolnshire Joint Formulary Recommends 1. Spironolactone 2. Eplerenone

Step 1- Assess whether suitable for treatment

- Current or previous symptomatic heart failure (NYHA II-IV)
- Already on optimal pharmacological treatment
- No evidence of hypovolaemia
- Inform patient of purpose, benefits & possible side effects of spironolactone

AA/MRA contraindicated

- Serum potassium > 5mmol/l
- Serum Creatinine >220
- Avoid if eGFR / EPI <30
- Caution if mild to moderate renal impairment
- Caution if using in the frail and elderly if they are taking ACE inhibitors

Step 2- Check U&Es and review use of potassium supplements and potassium sparing diuretics

- Potassium must be < 5mmol/l to continue
- Consider stopping potassium supplements and potassium sparing diuretics
- Continue ACE inhibitor, loop diuretics, Digoxin and Beta blocker if also prescribed.

Adverse Effects

- **Potassium > 5.5mmol/l**
 - Consider other factors eg urinary tract infection and manage as appropriate
 - Reduce dose to 25mg on alternate days or 12.5mg daily
 - Repeat bloods 5-7 days later
- **Potassium >6mmol/l on 25mg alternate days or 12.5mg - stop and review renal function again in 5-7 days**
- **Gastro-intestinal disturbance**
 - Stop and if has diarrhoea repeat U&Es at earliest convenience
- **Breast enlargement or tenderness**
 - stop spironolactone and replace with eplerenone

Step 3 – Spironolactone or Eplerenone initiation

- Commence at 25mg od

Step 4 – Monitoring

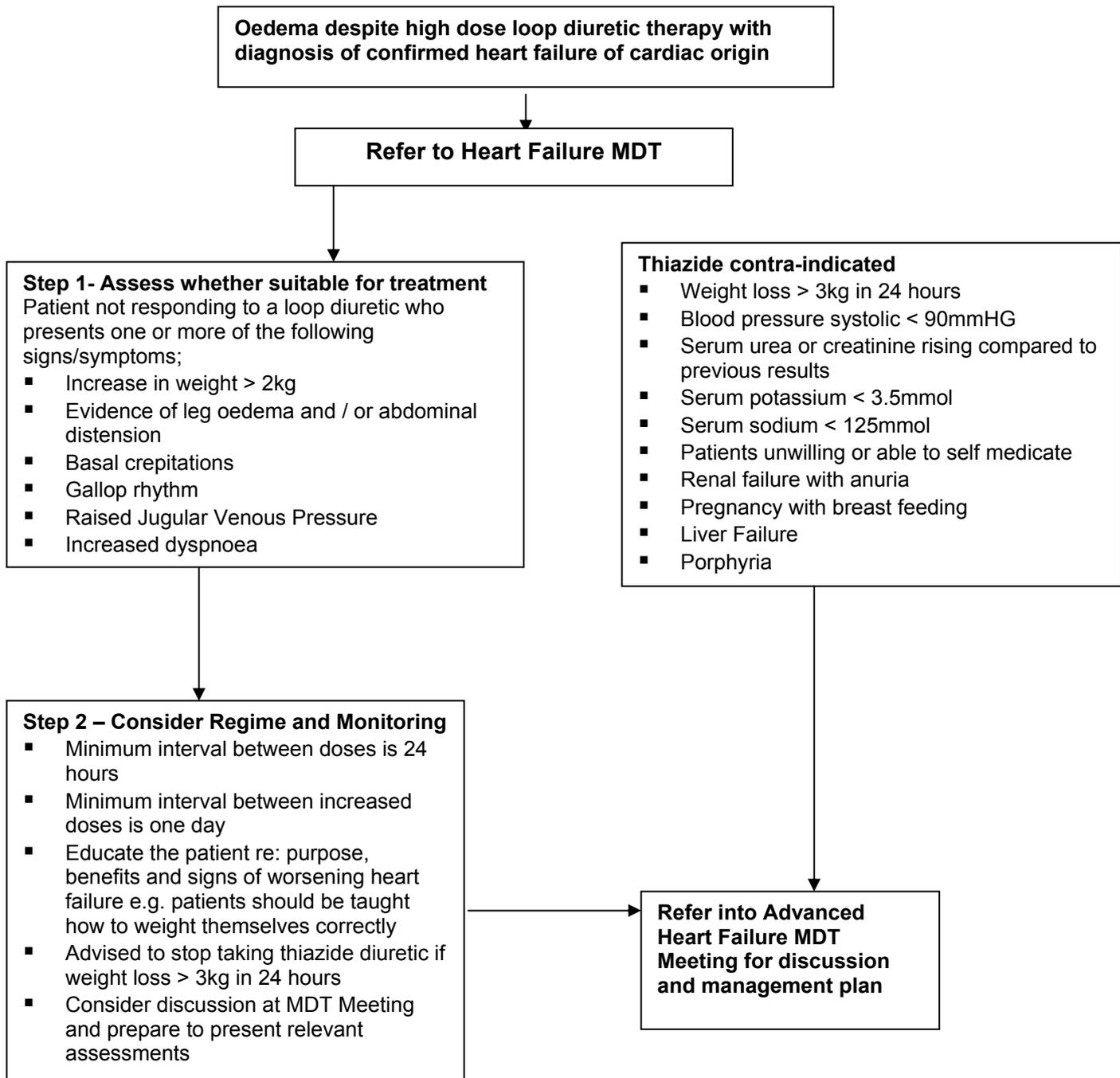
- Repeat U&E at 1, 4, 8 & 12 weeks and every 3 months thereafter.

If intolerant of spironolactone due to breast enlargement or tenderness – replace with eplerenone and review

Refer to Specialist Heart Failure MDT

If clinically unstable

Algorithm for the use of Combination Diuretic (Specialist Initiation and Monitoring)



Algorithm for the use of Ivabradine in Heart Failure (Specialist Initiation)

**Confirmed Left Ventricular Systolic Dysfunction (LVSD)
NYHA Class II-IV Ejection Fraction \leq 35%**



SINUS RHYTHM

**HR \geq 75 on optimal betablocker and ACE Inhibitor therapy
or
High pulse rate and intolerant /contra-indication to
betablocker
And
Stable heart failure for 4 weeks**



Commence Ivabradine 5mg b.d.

Review 2 weeks

If:

Resting Heart Rate > 60bpm - Increase to 7.5mg b.d.

Resting Heart Rate <50bpm – Decrease to 2.5mg b.d.

Lincolnshire Joint Formulary has approved use of Ivabradine under specialist initiation

Management of Arrhythmias

Bradycardia and atrio-ventricular block in patients with heart failure with reduced ejection fraction and heart failure with preserved ejection fraction – refer for specialist cardiology review and see ESC heart failure guidelines

Atrial Fibrillation

Atrial fibrillation is the most common arrhythmia seen in heart failure and management should include classification, identification and correction/ management of any underlying causes / precipitating factors.

Management to be informed by current NICE or ESC Guidelines and assessment carried out for thrombo-embolism prophylaxis



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Guidelines_Focused_L1



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guidelines-afib-ft.pdf



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and Chronic-HF-FT.px

Consideration of Anticoagulation for People with Heart Failure

Evidence suggests an increased thrombo-embolic risk associated with heart failure and left ventricular systolic dysfunction compared to the general population (ventricular or deep venous thrombus associated with ventricular dysfunction, arrhythmia, low cardiac output, peripheral oedema and immobility)

Atrial Fibrillation should be classified and managed according to NICE/ ESC Guidance

Assessment for thrombo-embolism prophylaxis should be undertaken using **CHA2DS2-VASc** Score :

Cardiac Failure or LVEF \leq 40 (Score 1)

Hypertension (Score 1)

Age \geq 75 years (Score 2)

Diabetes (Score 1)

Stroke (Score 2)

Vascular Disease (Score 1)

Age 65-74yrs (Score 1)

Sex (female) (Score 1)

CHA2DS2-VASc Score 0 = Recommend no antithrombotic

CHA2DS2-VASc Score 1 = Recommend antithrombotic therapy with oral anticoagulation or antiplatelet (preferably oral anticoagulation)

CHA2DS2-VASc Score 2 = Recommend oral anticoagulation

Where anticoagulation is indicated the **HAS-BLED** score is advised to assess risk of bleeding:

Hypertension (systolic blood pressure $>$ 160mmHg) (Score 1)

Abnormal Renal and Liver Function (Score 1 point each)

Stroke (Score 1)

Bleeding Tendency or Predisposition (Score 1)

Labile international normalized ratio if on warfarin (Score 1)

Elderly (age $>$ 65yrs) (Score 1)

Drugs (e.g. concomitant aspirin, NSAID) or alcohol (Score 1 point each)

HAS-BLED score \geq 3 suggests caution is warranted when prescribing oral anticoagulant and close monitoring is recommended.

Algorithm for the use of cardiac synchronisation (CRT) therapy &/or internal cardioverter defibrillators (ICD), or both (CRT-D) Based on NICE technology appraisal guidance 314 (2014)

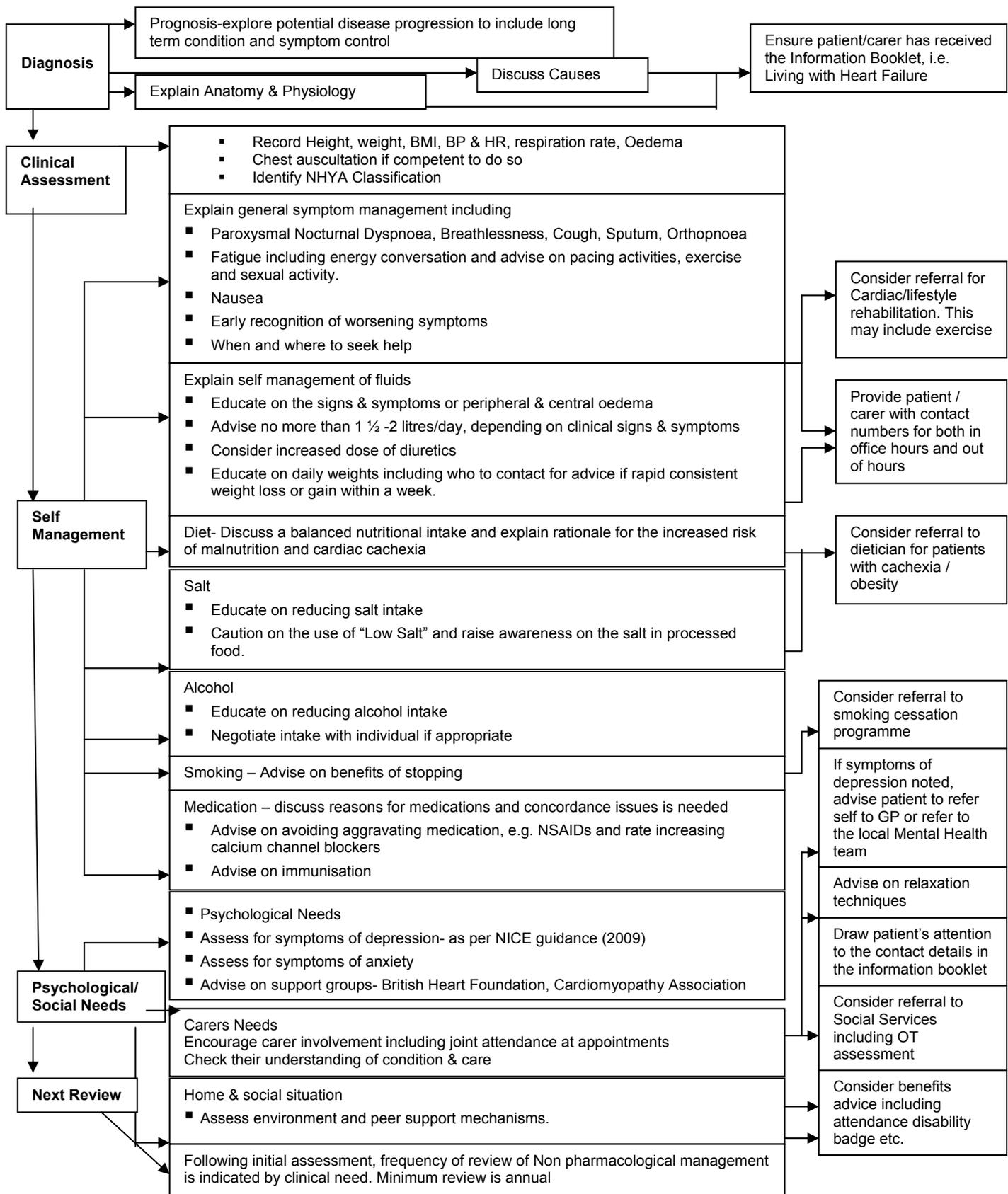
Table 1 Treatment options with ICD or CRT for people with heart failure who have left ventricular dysfunction with an LVEF of 35% or less (according to NYHA class, QRS duration and presence of LBBB)

QRS interval	NYHA class			
	I	II	III	IV
<120 milliseconds	ICD if there is a high risk of sudden cardiac death			ICD and CRT not clinically indicated
120–149 milliseconds without LBBB	ICD	ICD	ICD	CRT-P
120–149 milliseconds with LBBB	ICD	CRT-D	CRT-P or CRT-D	CRT-P
≥150 milliseconds with or without LBBB	CRT-D	CRT-D	CRT-P or CRT-D	CRT-P
LBBB, left bundle branch block; NYHA, New York Heart Association				

If meets criteria refer to cardiology for implantation at tertiary centre

N.B. Examples of where ICD indicated in primary prevention- A familial cardiac condition with a high risk of sudden death including long QT syndrome, hypertrophic cardiomyopathy, Brugada syndrome or arrhythmogenic right ventricular dysplasia, or have undergone surgical repair of congenital heart disease.

Algorithm for Non Pharmacological Management for 'Confirmed' Heart Failure



Sick Day Rules and Managing Heart Failure in Frail Older Patients

The following documents are included in this guidance to assist clinicians in managing medicines for heart failure patients who are on multiple medications for a range of co-morbid conditions. These patients may have little reserve to cope with acute illness and are at higher risk of admission to hospital if medication is not reviewed during these episodes.

The development of a Sick Day Rules card for Heart Failure patients aims to reduce this risk, particularly in respect of overdiuresis and acute kidney injury.

The cards were developed by Highlands NHS Trust initially and have been adapted to suit our patient group. The background research from the Highlands NHS Trust is included for reference.

<p style="text-align: right;">NHS</p> <p style="text-align: center; font-size: small;">Lincolnshire Community Health Services NHS Trust and United Lincolnshire Hospitals NHS Trust</p> <p>Advice on taking medication when sick</p> <p>When you are unwell with any of the following:</p> <ul style="list-style-type: none"> ▪ Vomiting or diarrhoea (unless just minor) ▪ Fevers, sweats and shaking <p>Then STOP taking the medicines listed overleaf</p> <p>Restart when you are well (after 24 - 48 hours of eating and drinking normally)</p> <p>If you are in any doubt, or your symptoms are not resolving, contact your pharmacist, GP or nurse.</p>	<p>Medicines to stop on days when sick</p> <ul style="list-style-type: none"> ▪ Angiotensin Converting Enzyme Inhibitors (ACEI's) – a medicine with a name ending in 'pril' eg ramipril, lisinopril, trandolopril, perindopril ▪ Angiotensin Receptor Blockers – medicine name ending in 'sartan' eg .candesartan, losartan, valsartan, irbesartan ▪ Non-Steroidal Anti-Inflammatory Drugs - painkillers eg .ibuprofen, nurofen, diclofenac, naproxen ▪ Diuretics or 'water pills' – eg. Furosemide, bumetanide, bendroflumethazide, metolazone, spironolactone, eplerenone, amiloride, co-amilofruse ▪ Metformin a medicine for diabetes
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NHSH-interim-evaluation-medicine-sick-day

We have also chosen to highlight the START – STOP Toolkit from Cumbria as a tried and tested aid to reviewing polypharmacy in frail older people.



StopstartToolkit2011.pdf

The appendices now also contain the following:

- Self Monitoring and Management Prompt that is provided to patients to enable them to seek appropriate review when unwell
 - A Quick Guide to Heart Failure Management for Lincolnshire

Advanced Heart Failure Management including management of symptoms commonly experienced in advanced heart failure

Indication for the development of this clinical guidance

Heart Failure is very difficult to palliate effectively and there are many disease specific barriers to palliation.

Many previously published guidelines for heart failure focus on active interventional aspects of management rather than palliation of the disease.

Patients with advanced heart failure have a poorer prognosis than that of many cancers. However it is recognised that patients with advanced heart failure do not have the same awareness, knowledge and access to palliative care services that patients with other terminal illnesses have and;

- Tend to be less involved in decision-making regarding treatment or non-treatment
- Do not perceive themselves as "dying"
- Experience frustrations with progressive loss (social and physical), complex medical regimes, social isolation and exclusion, poorly co-ordinated services and little palliation of symptoms

Common Symptoms and Problems Experienced by Heart Failure Patients

- Breathlessness
- Cough
- Fatigue
- Peripheral oedema
- Nausea and Vomiting
- Sleep Disturbance
- Pain
- Anorexia and weight loss
- Agitation and Delirium
- Increasing Dependence on others
- Psychological Concerns: Depression and Anxiety
- Constipation
- Itch
- Carer crisis

These guidelines aim to provide advice on the above. It is important to remember that many symptoms can be iatrogenic in nature; some of these are listed also.

Guidance as to when a Heart Failure Patient becomes “Palliative”

1. You would not be surprised if this patient were to die in the next 6-12 months based on your intuition which integrates co-morbidity, social and other factors.
2. Choice/ Need-patient makes a choice to have only comfort care and no curative therapy or is believed to need supportive/ palliative care
3. **Clinical Indicators**
General
 Multiple co-morbidities
 Weight loss greater than 10% over 6 months
 General physical decline
 Serum albumin <25g/l
 Reduced performance status
 Dependence in most activities of daily living

At least 2 of the Indicators specific to Heart Failure

New York Association Class III or IV despite optimal tolerated therapy
 Repeated episodes of symptomatic heart failure (this may be seen in terms of repeated hospital admissions or intensive community management) often with shorter periods of stability in between episodes.
 Difficult physical or psychological symptoms despite optimum tolerated therapy
 Deteriorating renal function Chronic Kidney Disease stage 4 or 5
 Failure to respond within 2-3 days to changes I diuretic or vasodilating drugs

Place patient on Palliative/ Supportive Care Register
 Issue green Card and Fax Out of Hours/Rapid Response Handover sheet & complete DS1500
 If days to weeks prognosis ensure pre-emptive plan and drugs are organised if appropriate

Consider Referral into the Advanced Heart Failure MDT or a member of the Specialist Heart Failure MDT

Issues for consideration when assessing patient's needs

Diagnosis and prognosis should be discussed using the principles established as good practice for "Breaking Bad News" as per East Midlands Guidance;

<http://www.eastmidlandscancernetwork.nhs.uk/Library/BreakingBadNewsGuidelines.pdf>

or those available within the Palliative Adult Network Guidelines <http://book.pallcare.info>

Bear in mind that many heart failure patients and their families have little comprehension of the severity of their illness. Exploration of patient's expectations may be of benefit.

Prognosis is particularly difficult to estimate in heart failure and underlying causes of deterioration in condition/ symptoms such as infection should be treated before considering prognosis in light of indicators.

Preferred Priorities of Care

Preferred Priorities of Care should be discussed and documented. Further information can be found using the link below to assist with planning for future care;

<http://www.nhs.uk/Planners/end-of-life-care/Pages/advance-statement.aspx>

http://www.ncpc.org.uk/sites/default/files/planning_for_your_future_updated_sept_2014%20%281%29.pdf

The complexity of chronic heart failure necessitates an individualised approach to the risks and benefits of various medical therapies and should be led by a member of the Specialist Heart Failure MDT (NICE, 2010).

This multidisciplinary process should always include the patient. Medicines management should be an ongoing process ensuring optimal medical management suitable to stage of disease, e.g. withdrawal of statin therapy in last weeks of life.

Discussion of resuscitation status should be undertaken with the patient and their family/carers and documented in patient's records. When a patient, in conjunction with their healthcare professional has made a decision not to be resuscitated, the East Midlands Do Not Attempt Resuscitation documentation should be completed and the original kept in the patients home;

<http://www.emas.nhs.uk/EasysiteWeb/getresource.axd?AssetID=37116&type=full&servicetype=Attachment>

Further guidance on completing this form can be found at:

<http://www.emas.nhs.uk/contact/care-decisions/>

Where a decision regarding resuscitation status is required to be made on the patient's behalf by a senior clinician the local organisation's Allow Natural Death Policy should be consulted;

Resuscitation is an important issue for people with heart failure as their risk of **sudden cardiac death** (SCD) is 50% higher than in the general population. SCD is also more prevalent in class I & II heart failure patients. The East Midlands Strategic Health Authority have produced a booklet for patients to consider their options;



Time_to_Talk_booklet[1].pdf

Following the issue of NICE guideline (TA314) there are now increasing numbers of people who will be fitted with an **implantable cardioverter defibrillators** (ICD). If someone has an ICD, there will need to be an open and honest discussion about when and how the defibrillator should be deactivated. Please see the Guidance included within this document for further advice (P44 & 48).

Patients should be asked if they have an **Advance Decision to Refuse Treatment (ADRT)** or have considered having one, please see the links for patient information and a sample ADRT form;

http://www.adrt.nhs.uk/pdf/ADRT_a_guide_May_2009.pdf

Most people are able to make decisions regarding their care, however if the clinician is unsure of the persons capacity to make a decision or if it has already been decided please see local organisational guidance

Information for patients to consider their choices should they lose their ability to make decisions in the future is also available;

<http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/opg-601-0409.pdf>

A Management Plan should be drawn up with the patient and a **written record provided. This should be communicated to other healthcare professionals as appropriate. Please see the included guideline regarding Decision Making in Advanced Heart Failure.**

Anticipatory prescribing and planning should be a priority and where appropriate patients should be supplied with a pack of anticipatory medications and local contact numbers, to avoid problems at nights, weekends and public holidays. The issue of a **green card** and faxing of a **handover sheet to Out of Hours (OOH) and Marie Curie Rapid Response** will allow **OOH** and emergency/response services staff to provide care more appropriately.

Provision of **supportive printed information** should be given where available and appropriate for example the **End of Life Booklet**;

<http://www.mariecurie.org.uk/Documents/PATIENTS-CARERS-FAMILIES/End-of-life/end-of-life-the-facts.pdf>

Carer Support

Consideration needs to be given to **carer support** and referrals to appropriate agencies made. The Lincolnshire Carers Partnership will perform a Carers Assessment and offer support;

<http://www.mychoicemycare.org.uk/i-need-help-with/being-a-carer/information-and-advice/lincolnshire-carers-partnership.aspx>

Follow up arrangements should be discussed and the patients should have clear understanding of what is likely to happen next, with the **Management plan** being reviewed at regular intervals.

If Community based **LCHS End of Life SystemOne Templates** should be completed as part of ongoing documentation within the patient's **Electronic Record**.

Palliative Care Heart Failure: Guidance on Care Package Considerations

Patients identified as being in Advanced Heart Failure should be placed on the GP held Palliative and Supportive Care Register (GSF) and referral made to the Heart Failure Complex Case Manager or a member of the Heart Failure MDT. Consider Plan of Care:			
Days	Days to Weeks	Weeks to Months	Months to Years
Preferred priorities of care	Preferred Priorities of Care	Identify preferred priorities of care and social care package	Social Care
Funding of Care	OOH/Marie Curie Rapid Response Green Card	DS1500 Benefit	Consider referral to: <ul style="list-style-type: none"> ▪ Support Group ▪ Benefits Advice ▪ Community Nurses ▪ Therapists ▪ Cardiac Rehabilitation (low intensity) ▪ Day Therapy at Day Hospice ▪ Advanced HF MDT ▪ Carer Support Group
Care Package	Apply for Continuing Care Funding	Continuing Healthcare Checklist	
Follow agreed local and national best practice guidance on care of dying adults	Care Package according to needs assessment	OOH/Marie Curie Rapid Response Green Card	
Co-ordination of Care by Identified team in Community	Community Nursing or Hospice at Home Support	Consider referral to: <ul style="list-style-type: none"> ▪ Support Group ▪ Welfare Advice ▪ Community Nursing ▪ Therapists ▪ Day Hospice for Palliative Rehabilitation ▪ Advanced HF MDT ▪ Specialist Palliative Care ▪ Carer Support Group 	
OOH Green Card	Advanced HF MDT as indicated		
	Specialist Palliative Care if required		
	Carer Support Group		

Management of Suspected Acute Confusion / Delirium

- Onset typically hours to days and clinical features, from which underlying cause may be elicited.

Common Clinical Features

- Restlessness, anxiety, sleep disturbance, irritability, emotional lability, anger, sadness, euphoria
- Disorientation
- Memory Impairment
- Disorganised thought processes, altered perception, illusions hallucinations, delusions
- Incoherent speech
- Attention span reduced, easily distracted
- Motor abnormalities such as tremor, altered tone and reflexes

Non- Pharmacological Management

- Listen to patient and try to explore their fears and anxieties. Psychological distress can manifest itself in hallucinations and nightmares
- Remain calm and avoid confronting the patient
- Try to keep patient in as normal and familiar a routine and place as is possible.
- Explore perceptions and validate those that are accurate
- Explain clearly what is happening and why to patient and carer(s)
- Try to provide an action plan for what can be done
- Explain management plan and repeat information to assist retention by patient and family
- If medication is required ensure the length of treatment course is discussed and stress that delirium is not mental illness but a state in which periods of lucidity can be expected.
- Do not use restraints and allow to mobilise if safe to

Treat Underlying Causes

- Infection
- Hypoxia
- Urinary retention
- Faecal Impaction
- Hyponatraemia
- Hypo/hyperglycaemia
- Renal Impairment
- Hepatic Impairment/congestion
- Drug toxicity-beta blockers, digoxin, anti-cholinergics
- Drug withdrawal-opioids, alcohol, benzodiazepines, SSRIs, nicotine
- Unrelieved pain

Pharmacological Management

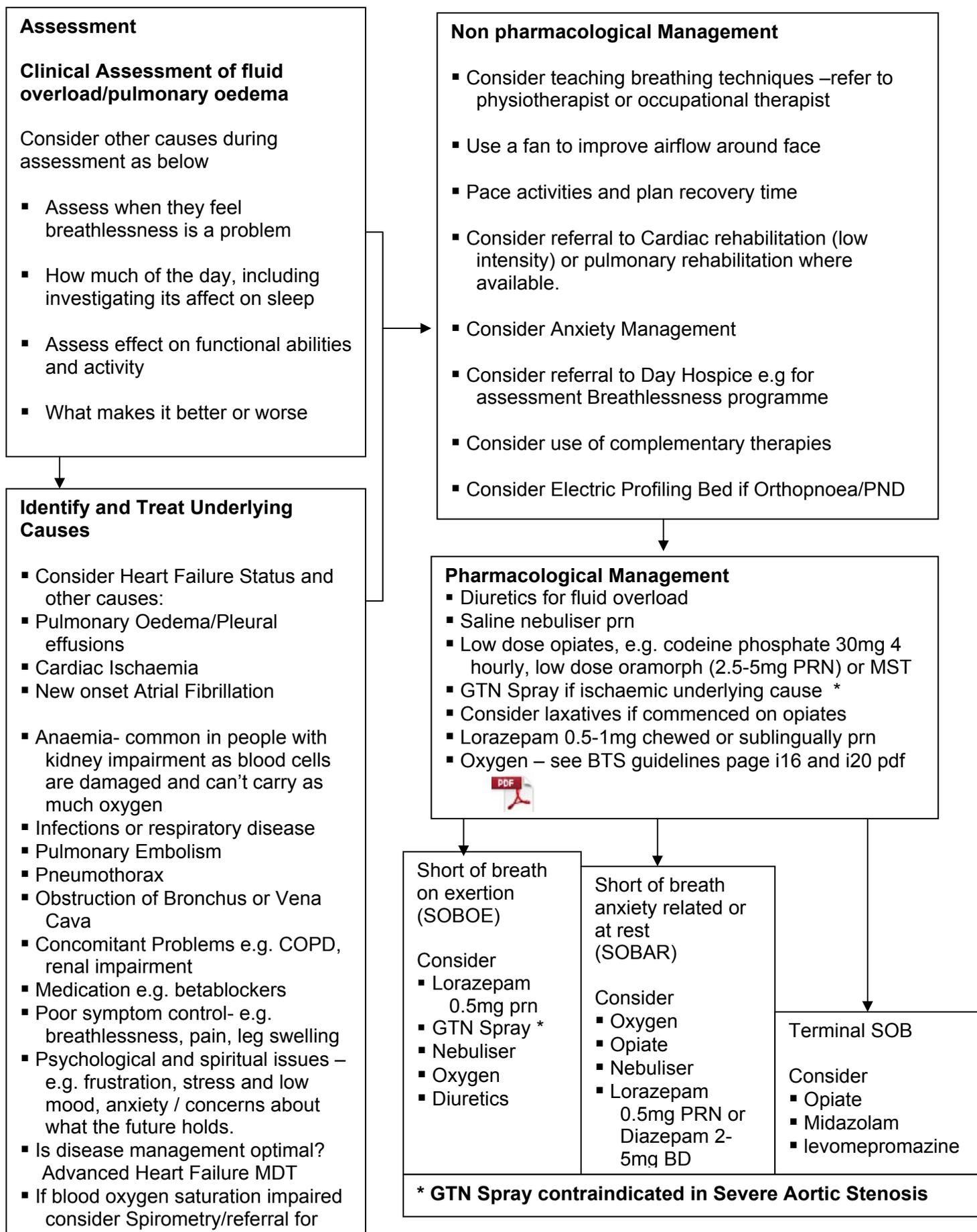
- Benzodiazepines should not be used alone** as they can worsen delirium (unless associated with alcohol withdrawal)
- Consider:**
- Haloperidol** either PO,SC (low dose in elderly but can be increased if poor response)
 - Haloperidol + Benzodiazepine** e.g. diazepam or midazolam
 - If severe Midazolam and levomepromazine** combined may be necessary to provide sedation in palliative context
 - Consider use of a syringe driver**

If No Improvement after exclusion of underlying causes or it is inappropriate to treat:

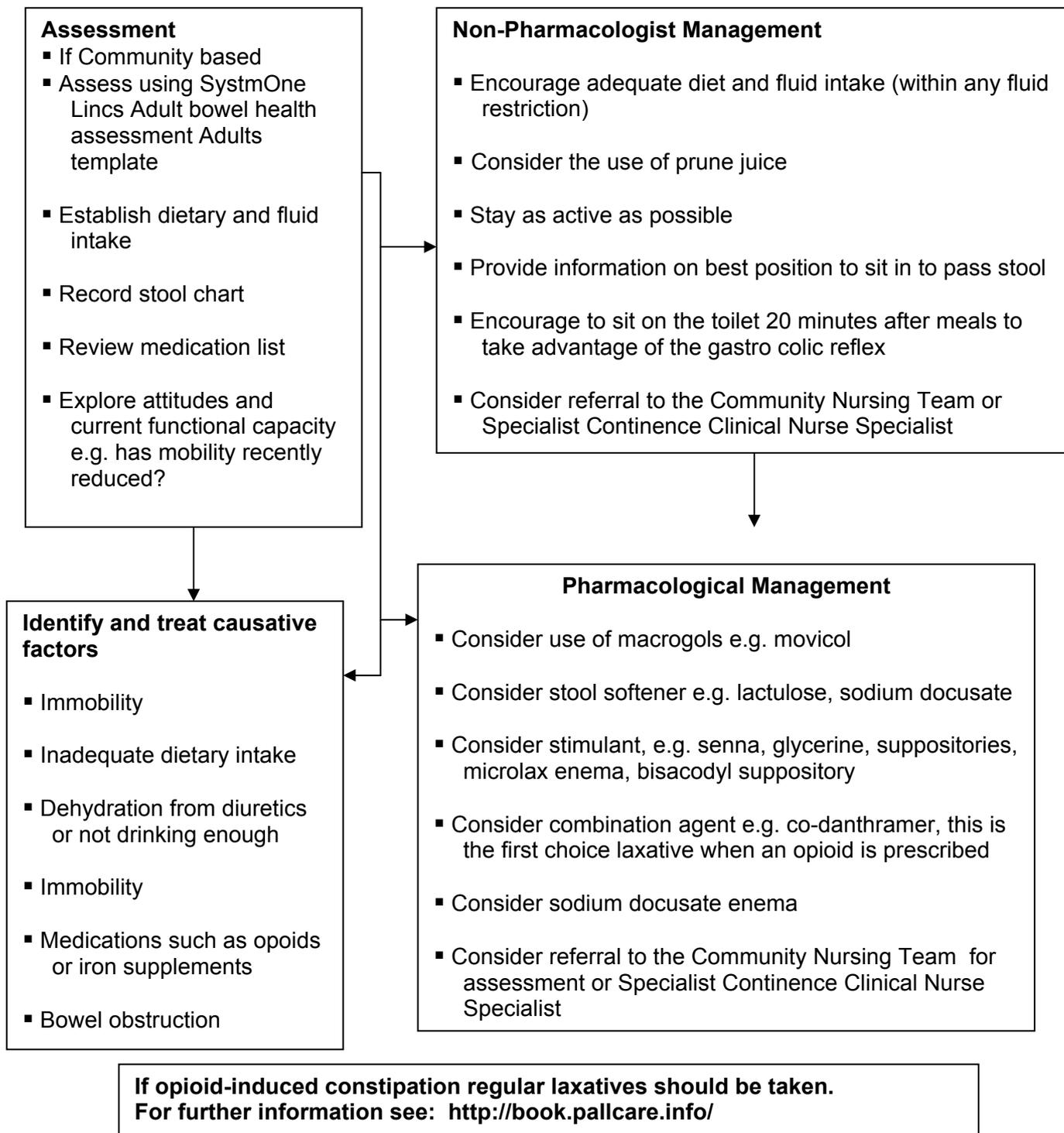
Consider whether this is Terminal Restlessness, which is a feature of dying.

If dying is diagnosed follow Liverpool Care Pathway

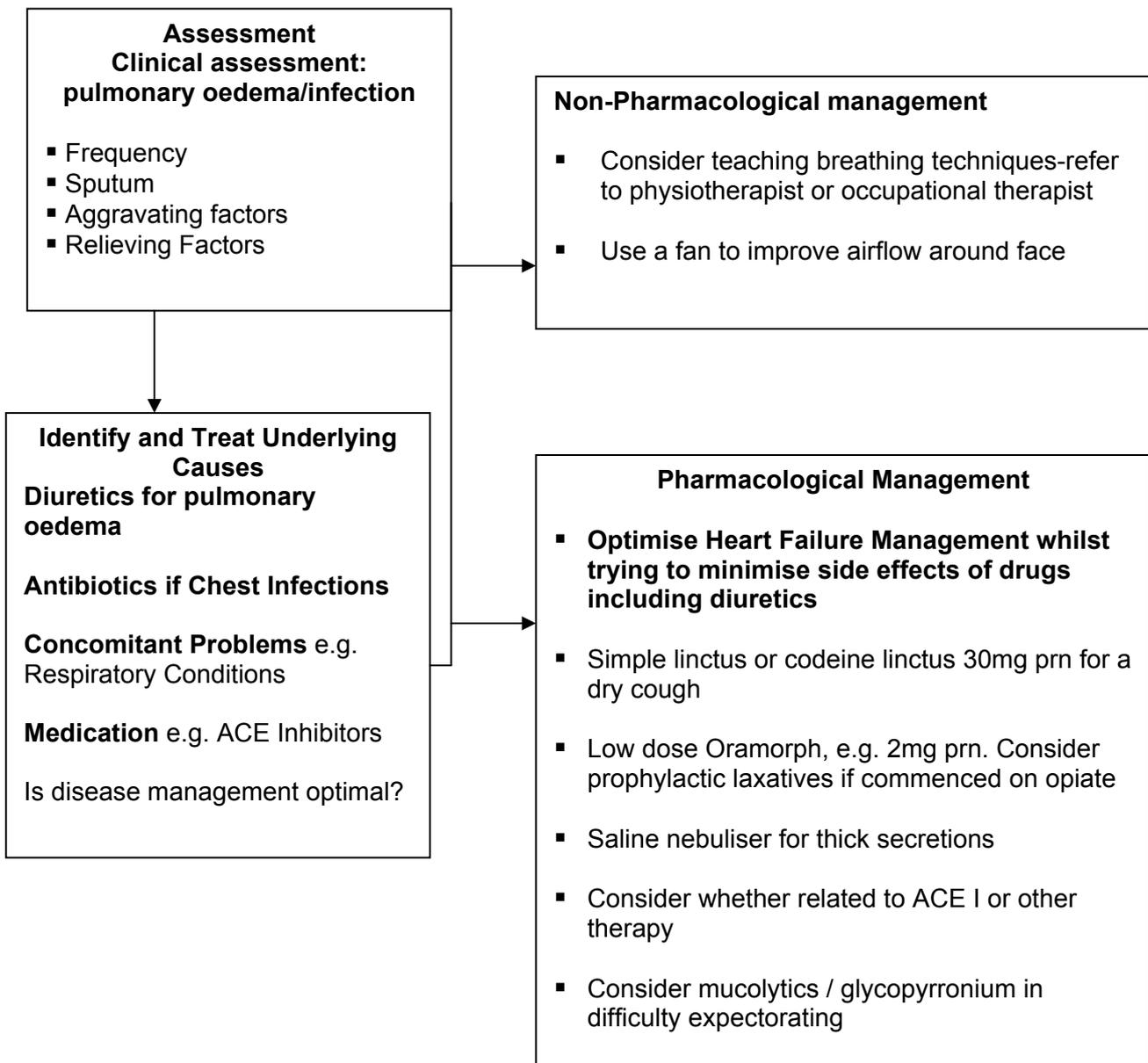
Management of Breathlessness



Management of constipation



Management of Cough



Management of Fatigue

Assessment of symptoms and possible causes

- **Low cardiac output is a key cause in heart failure**
- Assess when they feel fatigued, how much of the day, including investigating sleep patterns both at night and day
- Assess functional abilities and activity patterns e.g. if able to wash and dress, how long it takes, how they feel afterwards etc.
- Consider if due to Cardio-Respiratory deconditioning
- Consider other causes such as Anaemia/Hypo/Hyperthyroidism

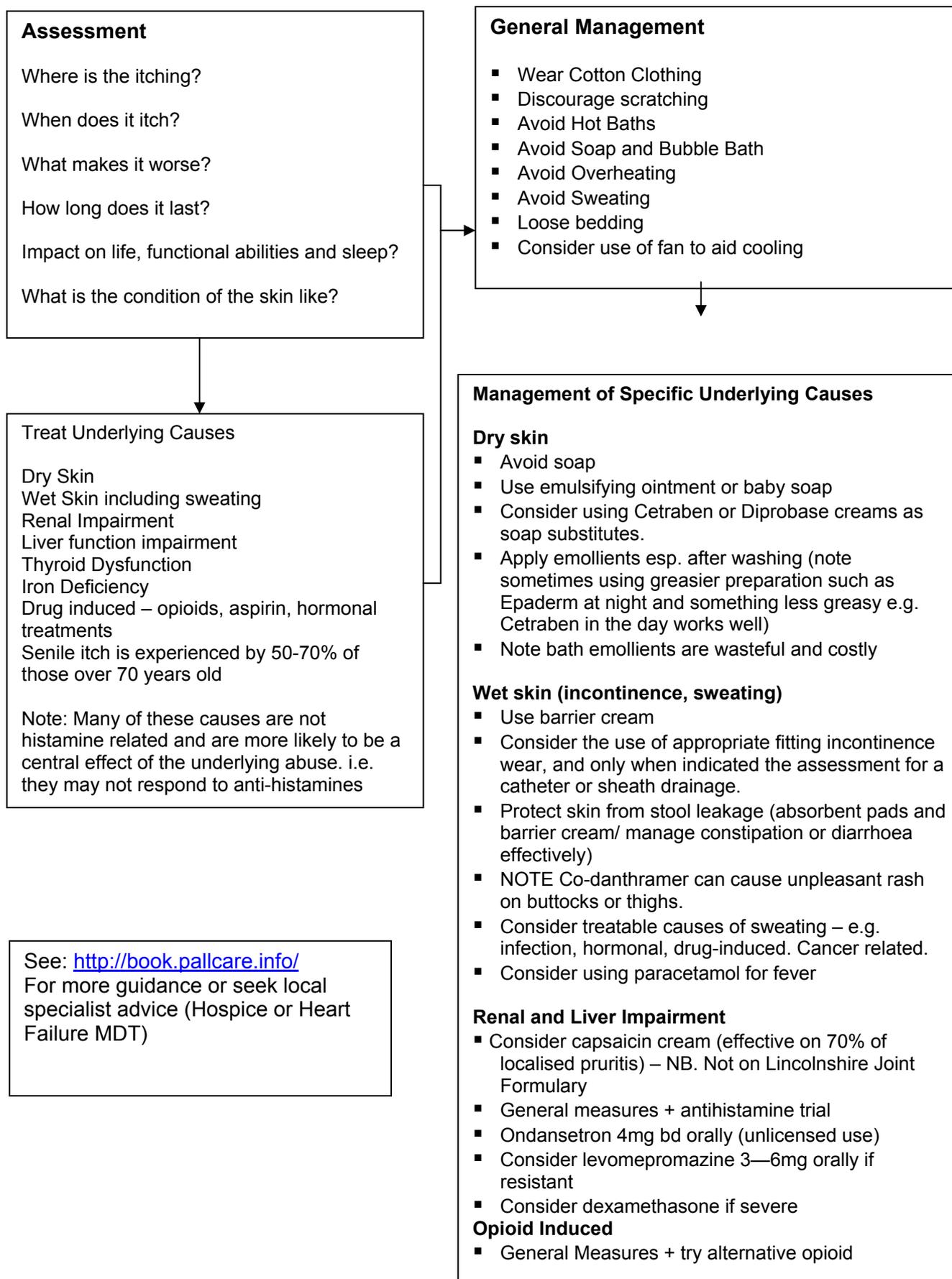
Pharmacological Management:

- Consider referral to the Heart Failure MDT for a review of medications/whether device therapies would be indicated
- Optimisation of Heart Failure Therapies
- Or reduction in Heart Failure Therapies due to the effects of symptomatic hypotension / hypovolaemia / hyponatraemia

Non-Pharmacological management of Fatigue

- Encourage the patient to:
- Eat small regular meals
- Exercise regularly (even a very small amount)
- Plan activities, but plan to do what they can definitely achieve, nothing what they completed and what they had to stop before finishing
- Plan to rest after each activity and after meals for a short time
- Keep a diary and note when the best and worst parts of the day are, then use the best times to undertake activities
- Plan to do less on days when you will be tired, e.g. plan less on the day of a hospital appointment and the day after as energy will be needed to get there and to recover afterwards
- Consider referral to cardiopulmonary Rehabilitation, Physiotherapy activity programme or palliative rehabilitation
- Make adaptations to home to aid energy conservation
- Energy conservation advice sheet
- Review Home Care package
- Consider referral to support Group or Expert Patient Programme

Management of Itching / Pruritis



Special Issues for Consideration when Managing Pain in Heart Failure

▪ Types of Pain

- Adequate pain assessment is vital
- Attempt to define the origin(s) of the patient's pain
- Major types of pain are: musculo-skeletal, somatic, neuropathic, spasmodic, pain of a psychical nature (also referred to as spiritual pain).

▪ Not all pains are opiate responsive

- Somatic pain is usually very responsive to opiates
- Some musculo-skeletal and neuropathic pains may respond partially to opiates but may require the addition of adjuvant analgesics
- See Palliative Adult Network Guidelines; <http://book.pallcareinfo>

▪ Remember the Analgesics Ladder

- Problems associated with opiate toxicity can be avoided by following the steps outlined in the ladder.
- Always Start Low with opiate Doses and Go Slow when increasing

▪ Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

NSAIDs ARE NOT RECOMMENDED FOR USE IN HEART FAILURE

- In RARE circumstances the risk of increased oedema and/or worsening renal function associated with the use of NSAIDs can be outweighed by the benefit to the patient in terms of pain relief

▪ Trans-dermal Analgesics

- Buprenorphine and Fentanyl Patches are being increasingly used in the management of non-malignant chronic pain. They are designed to be used for **stable opiate sensitive pain and should not be used for acute pain relief or where titration of analgesia is required.**
- Their use in the terminal, end of life situation is problematic for many reasons and their substitution/replacement with an alternative form of opiate should be considered. The use of a syringe driver should be considered in these situations

▪ Routes of Administration

- In the presence of extensive peripheral and visceral oedema, the absorption of oral medication may be erratic, unpredictable.
- Consider other routes of administration sub-lingual, trans-dermal (avoid placing patches on oedematous areas), sub-cutaneous.

Management of Nausea and Vomiting

Assessment

- Consider if related to fluid overload/abdominal distension
- Assess symptom-nausea and or vomiting
- If vomiting, what is being produced?
- When are symptoms present
- Any precipitating factors e.g. eating food
- Any relieving factors
- Consider asking patient to keep a symptom diary
- Review after treating

Consider causative factors and correct where possible

- Drugs e.g. morphine or antimuscarinics
- Renal or liver dysfunction
- Gastric stasis caused by enlarged liver, constipation or gastric outflow obstruction
- Gut Oedema
- Constipation
- Anxiety
- Pain
- Infection
- Cough

Non-Pharmacological Management

- Consider psychological and spiritual care to treat anxiety
- Consider relaxation therapy, refer to physiotherapist/Occupational Therapist
- Consider Complementary therapy, suggest self referral to private provider or hospice

Pharmacological Management

Avoid cyclizine (increase heart rate and decreases cardiac output)

Review medication and identify risk/ benefit of any drugs believed to cause nausea or vomiting and discontinue therapy if appropriate.

- For chemical causes e.g. morphine, renal failure
 - Consider Haloperidol
- If nausea is constant or there is renal impairment/failure
 - Consider Haloperidol at night
 - Levomepromazine which has a sedative effect but may cause postural hypotension. Use in low doses (3-6mg) and cautiously with elderly people
- In palliative circumstances where nausea is related to meals or if the patient is vomiting undigested food, a short course of Metoclopramide 10mg tds or Domperidone 10mg tds may be considered following review of risks / benefits NB: Use in people with long QT interval / on drugs that lengthen QT interval or impaired liver function should be avoided

Management of Peripheral Oedema

Assessment

Assess Tissue Viability

- Colour
- Texture
- Temperature
- Skin assessment
- Cellulitis

Record daily weights if able to

Assess oedema including whether:

- Bilateral
- Height up leg
- Abdominal distension
- Sacral oedema
- Scrotal
- Pitting
- Sub-conjunctival/orbital

Identify and treat if appropriate any alternative underlying causes such as:

- Renal failure
- Low albumin
- Dependant oedema
- Infection
- Deep vein thrombosis
- Liver dysfunction
- Lymphoedema

Non-Pharmacological Management

- Rest
- Restrict fluid intake
- Sit with feet up and legs well supported when possible
- Review home support and arrange additional care as required
- Offer pressure relieving equipment
- Consider electric profiling bed
- Skin care

Pharmacological Management

Optimise diuretic therapy (see guideline diuretics in heart failure)

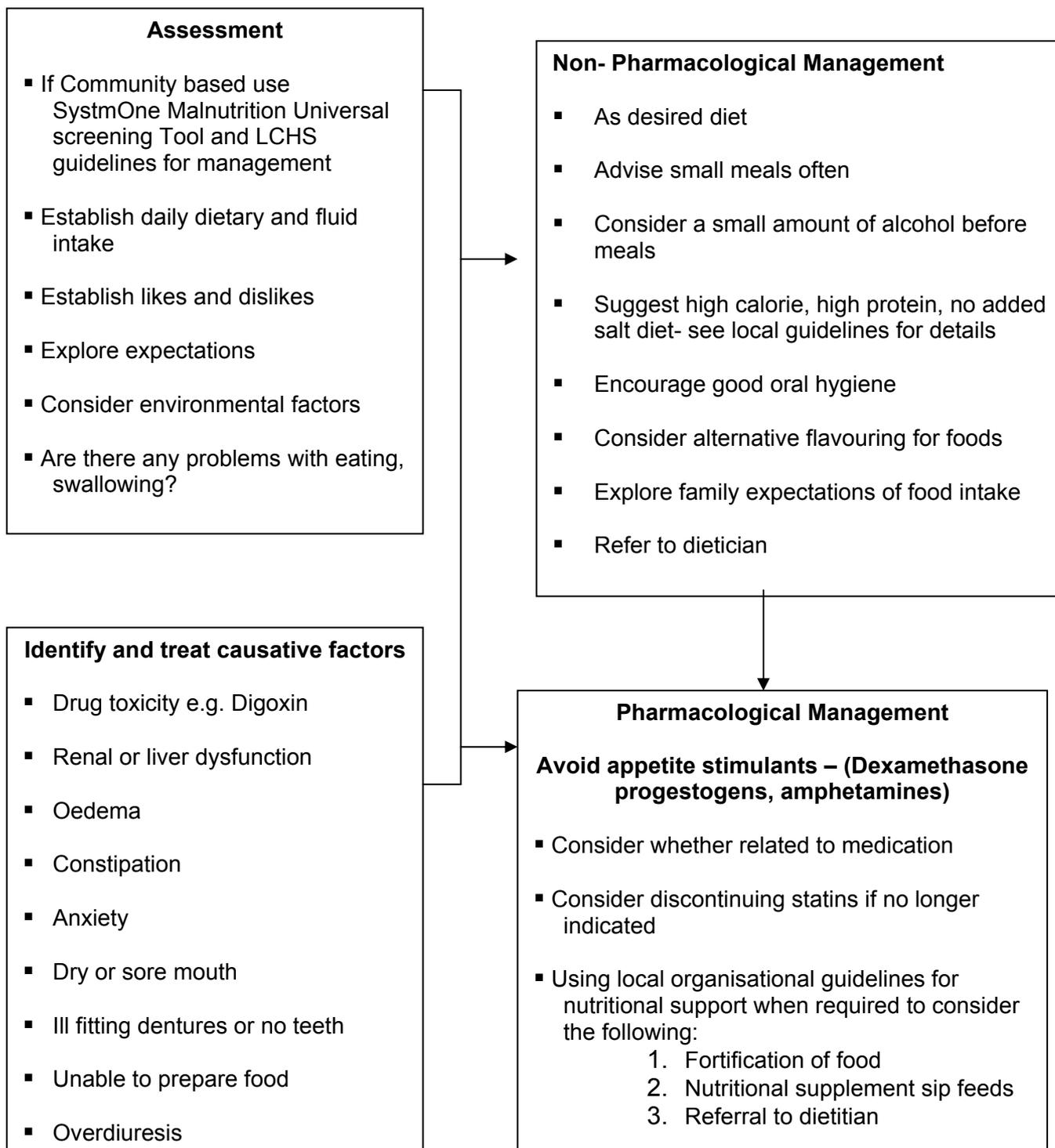
- First line is loop diuretic (Frusemide or Bumetanide)
- If NYHA II-IV consider the addition of an MRA/aldosterone antagonist (Spironolactone/Eplerenone)
- Resistant oedema may require the addition of a thiazide diuretic periodically and referral for specialist advice should be sought as careful monitoring of clinical status, renal and liver function is required in this group of patients
- Consider admission for Intravenous Diuretic therapy

Lincolnshire Joint Formulary Recommends:

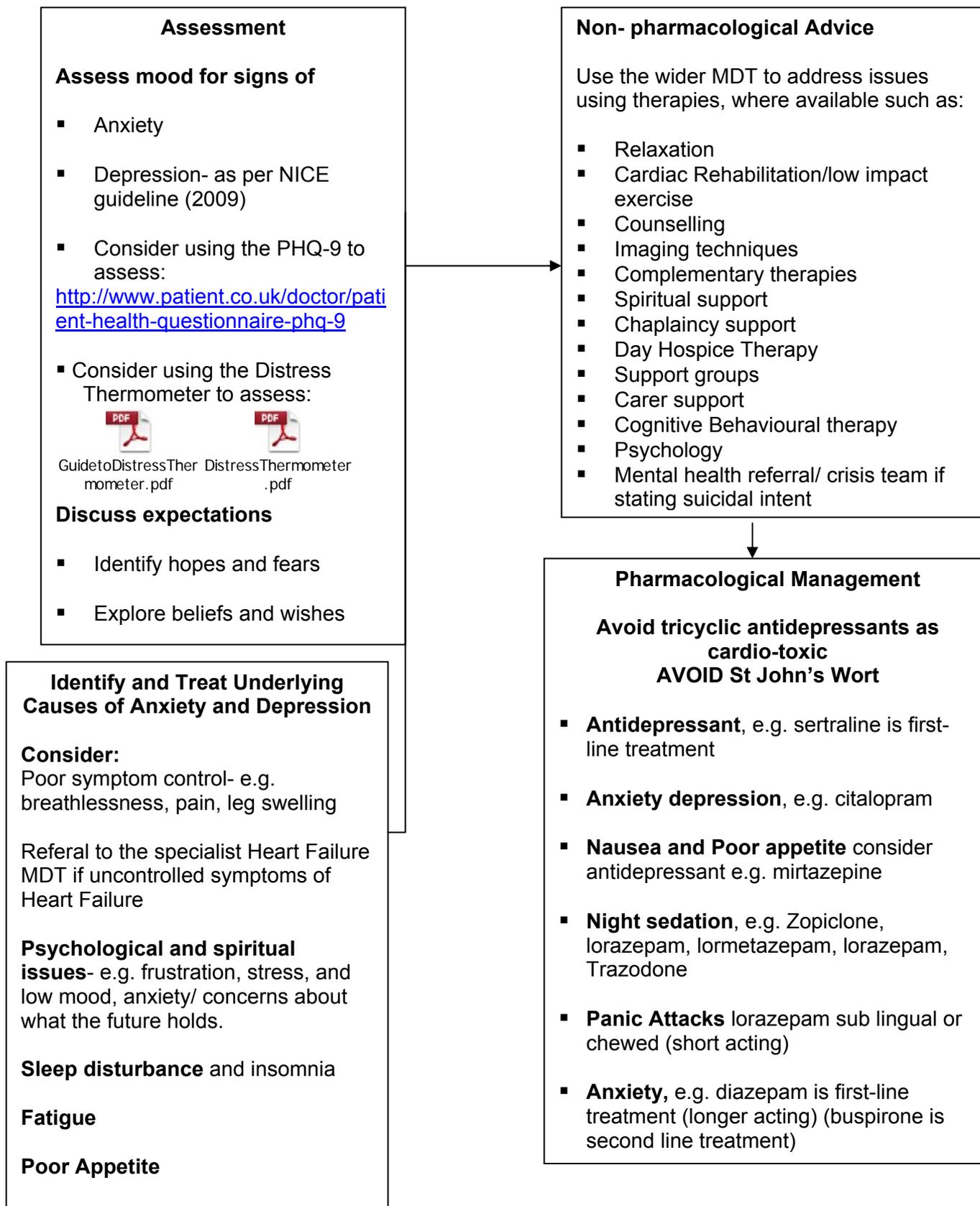
Loop Diuretic – 1. Furosemide 2. Bumetanide

AA/MRA – 1. Spironolactone 2. Eplerenone – use within license see P16 for details

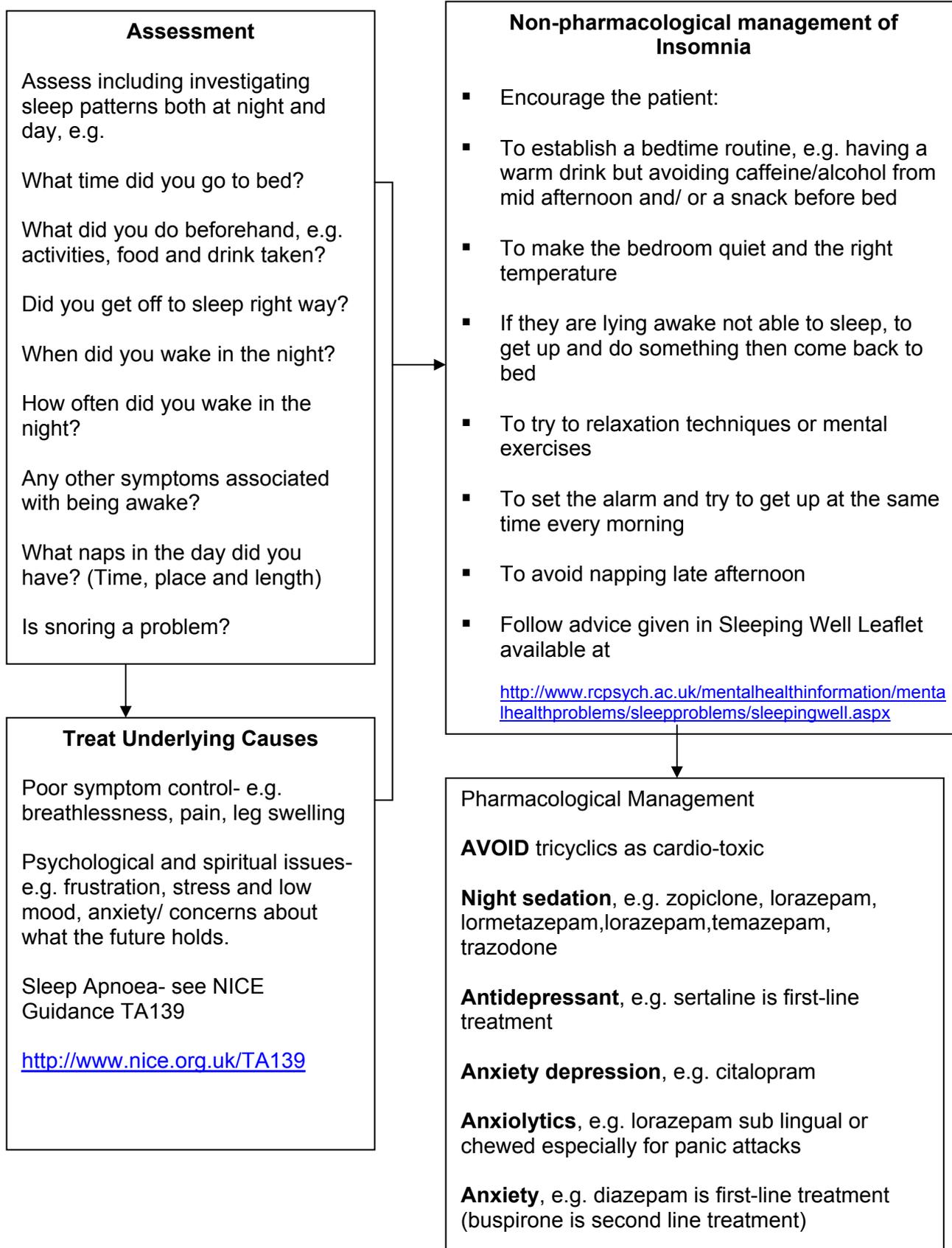
Management of Poor Appetite and Weight Loss/ Cachexia



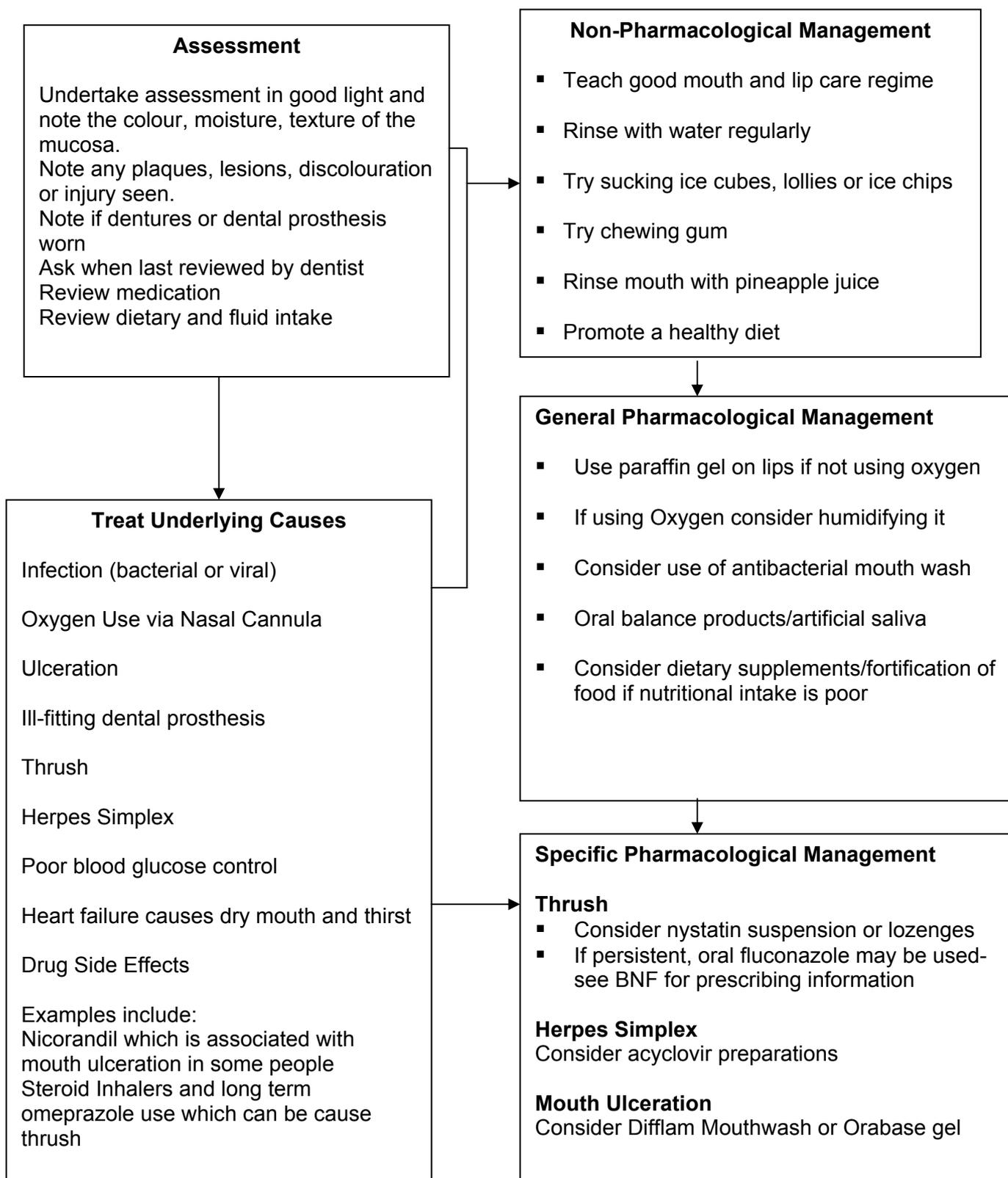
Psychological Concerns



Management of Sleep Disturbance and Insomnia



Management of Stomatitis / Sore Mouth



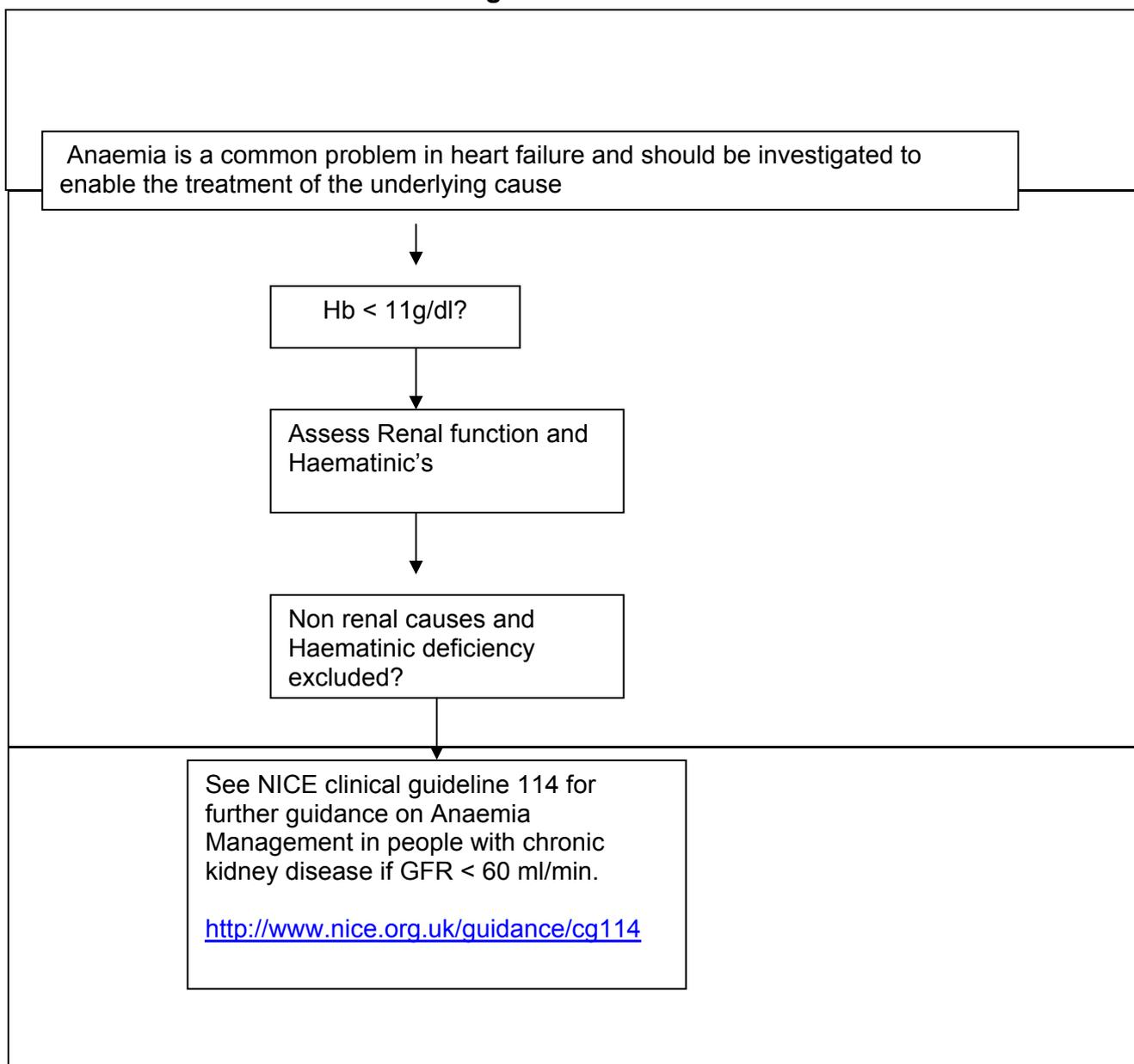
Medicines Management in Advanced Heart Failure

- Review Medications at each visit, look at packs and prescription if possible.
- Discuss with patients any problems or concerns they have.
- Ensure patient understands why they have been prescribed medication, explaining in particular about drugs that are prescribed for longer term mortality and morbidity gains as these are more likely to be stopped by patients who have no symptomatic gain from taking the drug. Many heart failure drugs are given to retard disease progression and fall into this category.
- Try to maintain ACE Inhibition, Betablocker, Mineralocorticoid Receptor Antagonist / Aldosterone Antagonist and Digoxin if possible as these all aid heart function and symptom control
- Consider whether the patient is taking their medication: If concerned that there may be an issue with concordance, consider reviewing dispensing dates on packs, number of tablets left in packs, compare prescriptions issued with those collected.
- Review whether patient or carer is able to dispense medication correctly from packs and if problems identified consider contacting local pharmacist for review in order to improve self management of medication – eg blister patient administration packs delivered weekly.
- Consider discussing any concerns with GP, Pharmacist or at Multidisciplinary Team Meeting.
- In palliative phase, consider stopping medications that derive no short term benefits such as statins.
- Diuretics are used only for symptom control and should be reviewed in light of signs and symptoms. They are often perceived as a nuisance – negotiation around timing is advised to ensure they are taken regularly rather than omitted altogether.
- Weigh up risks/benefits of therapies
- Use therapy guidelines where available to aid a systematic approach to care
- Consider best route for administration of essential medicines
- The use of drugs outside their license is more common in palliative care and there are some clearly identified instances in these guidelines. Clinicians should seek further advice from pharmacist/Specialist Heart Failure MDT/Specialist Palliative Care team before prescribing if they are unfamiliar with the use of that particular drug in these circumstances.
- **ALWAYS CONSIDER IMPACT OF LIVER AND RENAL FUNCTION IMPAIRMENT ON DRUG METABOLISM AND EXCRETION**
- **CONSIDER REFERRING TO RENAL FAILURE LAST DAYS GUIDANCE IF eGFR<30 for**



RenalLastDays.pdf

Management of Anaemia



Management of Gout

Gout is common in heart failure due to the use of diuretics.

The use of NSAID's or Corticosteroids is to be avoided in the management of acute gout in heart failure due to the risks of fluid retention/casing decompensating heart failure.

The preferred drug treatment is Colchicine with a view to commencing low dose Allopurinol once the acute attack has been treated

Please use this advice in the context of the Lincolnshire Joint Formulary Approved Algorithm for management of Gout (P43)

Management of Gout

During initial assessment of acute gout, please consider risk factors

If unsure of diagnosis please refer to a Rheumatologist

ACUTE TREATMENT
 Suppress pain and reduce inflammation until acute flare has subsided.

Please consider the following options

- Colchicine 500 mcg twice daily (usually adequate), increase up to four times daily if required (increased risk of diarrhoea).
- **OR** an NSAID (e.g. naproxen 500mg twice daily or ibuprofen 400mg three times daily). Please consider co-prescribing omeprazole or lansoprazole for gastroprotection.
- **OR** a corticosteroid (intra-articular, particularly if single joint) **OR** oral (e.g. prednisolone 20mg for 3 days, then 15mg for 3 days, then 10mg for 3 days then 5mg for 3 days and stop). Steroids are preferred if there are contraindications to NSAIDs.

Advise the patient to use an ice-pack. Measure serum urate levels and renal function after the attack. Serum urate levels measured during an attack may be lower than usual levels. Gout is part of the metabolic syndrome. Please look for and treat associated conditions such as diabetes, hypertension, hypercholesterolemia and obesity

LONG TERM TREATMENT (DRUG OF CHOICE IS ALLOPURINOL)

Treat to target. Aim for a serum urate of 300µmol/L or less (flare-ups less likely if target achieved)¹

(1). **Consider allopurinol 100mg daily.** Repeat serum urate levels every 2 to 4 weeks and increase dose by 100mg up to 900mg daily in single or divided doses until target urate levels are reached. Most patients will require about 300mg of allopurinol daily²

(2). Prophylaxis is required during the initial period of therapy in view of the increased risk of flare. Consider an NSAID (see above) or Colchicine 500 mcg twice daily. Prophylaxis should continue until the target urate level is reached (maximum period of six months)²

(3) Dietary advice.

(4) Allopurinol should be used with caution in patients with renal impairment. In moderate renal impairment (eGFR 30-50) use lower doses (maximum 100mg daily) and monitor renal function. Avoid using allopurinol in patients with severe renal impairment (e-GFR less than 30). The risk of hypersensitivity reaction to allopurinol is increased in renal impairment.

ALLOPURINOL SENSITIVITY or CONTRAINDICATION

Treat to target. Aim for a serum urate of 300µmol/L or less (flare-ups less likely if target achieved).

Consider febuxostat 80mg daily; monitor serum urate levels and LFTs at least monthly for the first 6 months and reduce frequency of monitoring afterwards. Febuxostat 80mg is usually adequate but if target is not reached increase to 120mg daily³.

Febuxostat is not recommended in patients with heart failure and ischaemic heart disease³

Febuxostat should be avoided in patients with severe renal impairment (eGFR less than 30). In renal impairment, febuxostat has an advantage over allopurinol because it is processed primarily by the liver and lowering of dose is not usually required. Renal monitoring is essential.

If febuxostat is contraindicated other options include benzbromarone (secondary care only). Please refer complex cases to a Rheumatology clinic. Sulfinpyrazone and probenecid can also be considered.

Gout flares while taking sUA lowering therapy

Suppress pain and reduce inflammation. Do not interrupt allopurinol or febuxostat therapy unless there is a clinical reason.

*Steroids or colchicine are preferable treatments for patients who have concomitant conditions and who are taking medications that contraindicate the use of NSAIDs (e.g warfarin) but they should be used with caution.

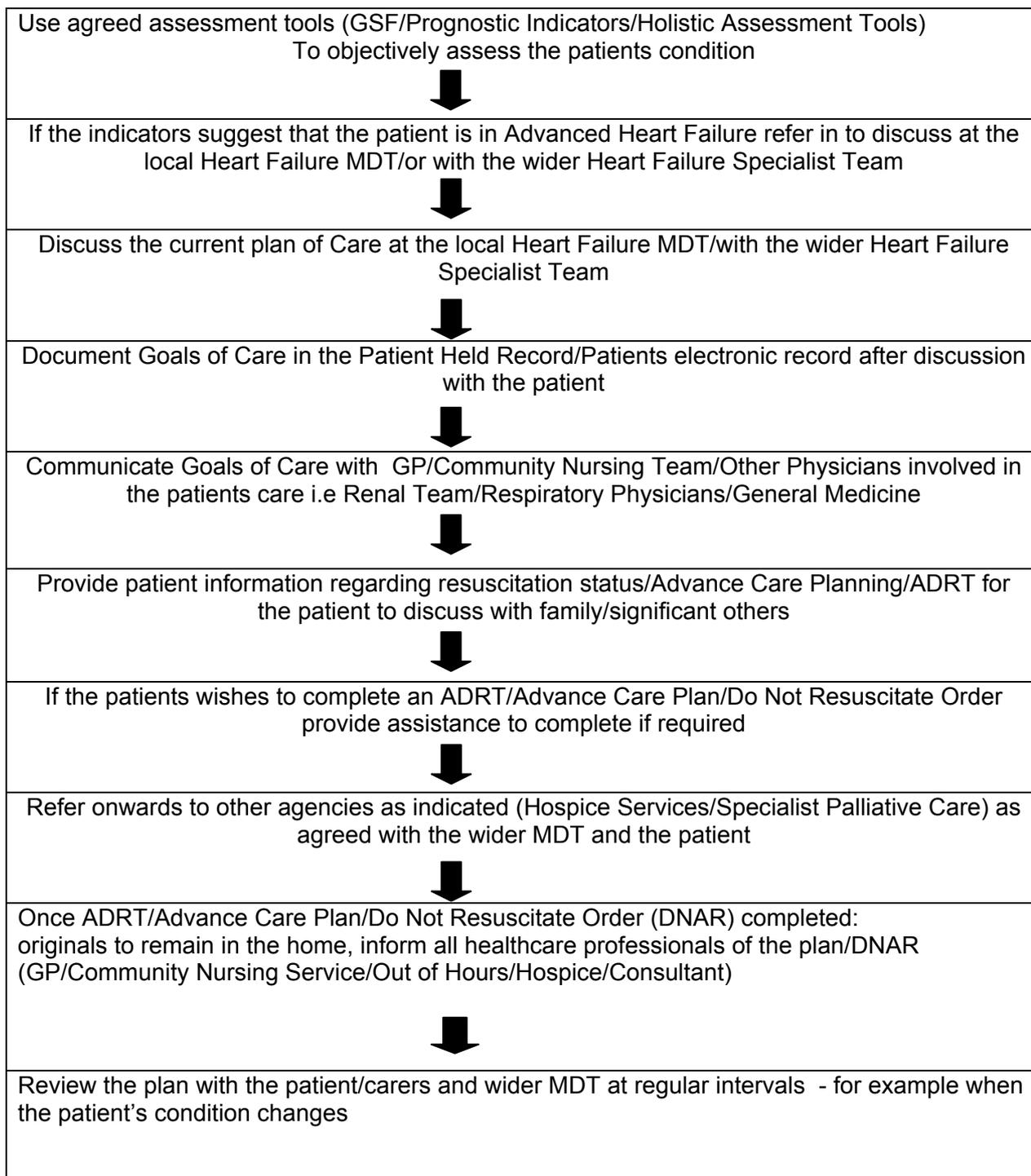
References

1. Jordan KM, Cameron JS, Snaith M et al. British Society for Rheumatology and British Health Professionals in Rheumatology guideline for the management of gout. *Rheumatology* 2007; 46: 1372-4.
2. Rider TG, Jordan KM The modern management of gout. *Rheumatology* (Oxford) 49; 5-14.
3. NICE Technology Appraisal 164 *Febuxostat for the management of hyperuricaemia in people with gout* (December 2008)

Produced by Dr Batsi Chikura (Consultant Rheumatologist at Lincoln County Hospital)
 May 2013

CAUTION: AVOID NON-STEROIDAL ANTI-INFLAMMATORY DRUGS AND CORTICOSTEROIDS IN CONTEXT OF HEART FAILURE

Pathway for Decision Making and Advance Care Planning for Patients with Chronic Heart Failure



Iatrogenic Problems

Iatrogenic Problems	Symptoms
Overdiuresis	Hypokalaemia Hypotension Falls Nausea Loss of appetite Confusion
Digoxin Toxicity	Nausea Loss of appetite Diarrhoea Abdominal Pain Confusion Bradycardia/ Heart Block Hypotension Loss of awareness of impending hypoglycaemia
Opiates	Confusion Constipation Dry Mouth Nausea Muscle Spasm (Myoclonus)
Steroids	Can precipitate deterioration in heart failure, renal function and blood glucose control.

Drugs to Avoid in Heart Failure

Cyclizine NSAIDS Steroids Calcium Channel Blockers Glitazones Amphetamines Progestogens Tricyclic Antidepressants St Johns Wort Domperidone Metoclopramide

Pathway for Deactivation of Implantable Cardioverter Defibrillators (ICD's) at End of Life**Indications for consideration of deactivation of ICD:**

- Patient preference in advanced disease
- In the event that the patient has completed an Advanced Decision to Refuse Treatment
- Approaching end of life when ICD activation would be inappropriate
- Following withdrawal of anti-arrhythmic drug therapy as per medicines review at end of life
- While an active DNAR order is in force

See CIEDs_Guidance PDF for further information and decision making flow charts Pages 55 and 56



CIEDs_Guidance.pdf

Process prior to deactivation:

- Open discussion with the patient, next of kin/carer or patient advocate as part of advance care planning
- Multidisciplinary review including cardiologist where appropriate You may wish to use the Arrhythmia Alliance leaflet for patient information:

<http://heartrhythmcharity.org.uk/www/media/files/ICD%20in%20Dying%20Patients.pdf>

Points of discussion may include:

- Resuscitation status and possible completion of an Advance Care Plan/ADRT/DNAR
- Withdrawal will not result in immediate death but the safety not provided by the device will no longer apply
- Deactivation is achieved using an external programmer and is not painful
- Multi-organ failure associated with electrolyte disturbance may be pro-arrhythmic and result in device discharge
- Inappropriate shocks are uncomfortable and inconsistent with symptomatic care
- Some ICDs incorporate both defibrillation and pacing modalities and it may be appropriate to selectively disable the defibrillation element as untreated bradycardias may exacerbate patient symptoms.

Procedure for deactivation:

- The patient should complete the locally agreed deactivation consent form-appendix 1
- Liaise with local senior cardiac physiologist based within the local acute hospital to arrange a mutually convenient time and appropriate place identified for deactivation
- Deactivation of ICD by cardiac physiologist

Community Heart Failure Complex Case Manager Service

Specialist Community Heart Failure Nurse Referral Criteria:

- **Objective evidence of significant cardiac dysfunction** – confirmed left ventricular systolic or diastolic dysfunction or at least moderate impairment of aortic or mitral valve function.
- AND EITHER
- **Recent hospital admission for deteriorating heart failure**
 - **Newly diagnosed heart failure with high risk of readmission**
 - **Unstable clinical condition in community setting**, as indicated by need for recent increase in diuretic dosage, with high risk of admission

NB: Objective evidence e.g. Echocardiogram, Angiogram, Myocardial Resonance Imaging

Service Offered

- Initial full assessment, from which a decision will be made as to whether case management is appropriate, with referral on to other services as indicated.
- Patients accepted onto caseload will be supported until heart failure symptoms are considered to be stable.
- Patients will be reviewed within 2 weeks if there is any significant change in symptoms / condition or medication relating to heart failure in line with NICE Guidance (2003)
- A review of appropriateness for case management will be undertaken 3 monthly
- The Heart Failure Specialist Team is part of a wider integrated community team which works with partners from other organisations to provide each patient with a suitable package of care to meet their health and social needs. This includes palliative care providers and social services.
- Care will be delivered as close to home as possible, with most patients receiving care in their own home (whether that be a private house, residential or nursing home), supplemented by telephone, clinic and hospital reviews as indicated.

Criteria for Discharge from HFCCM Service

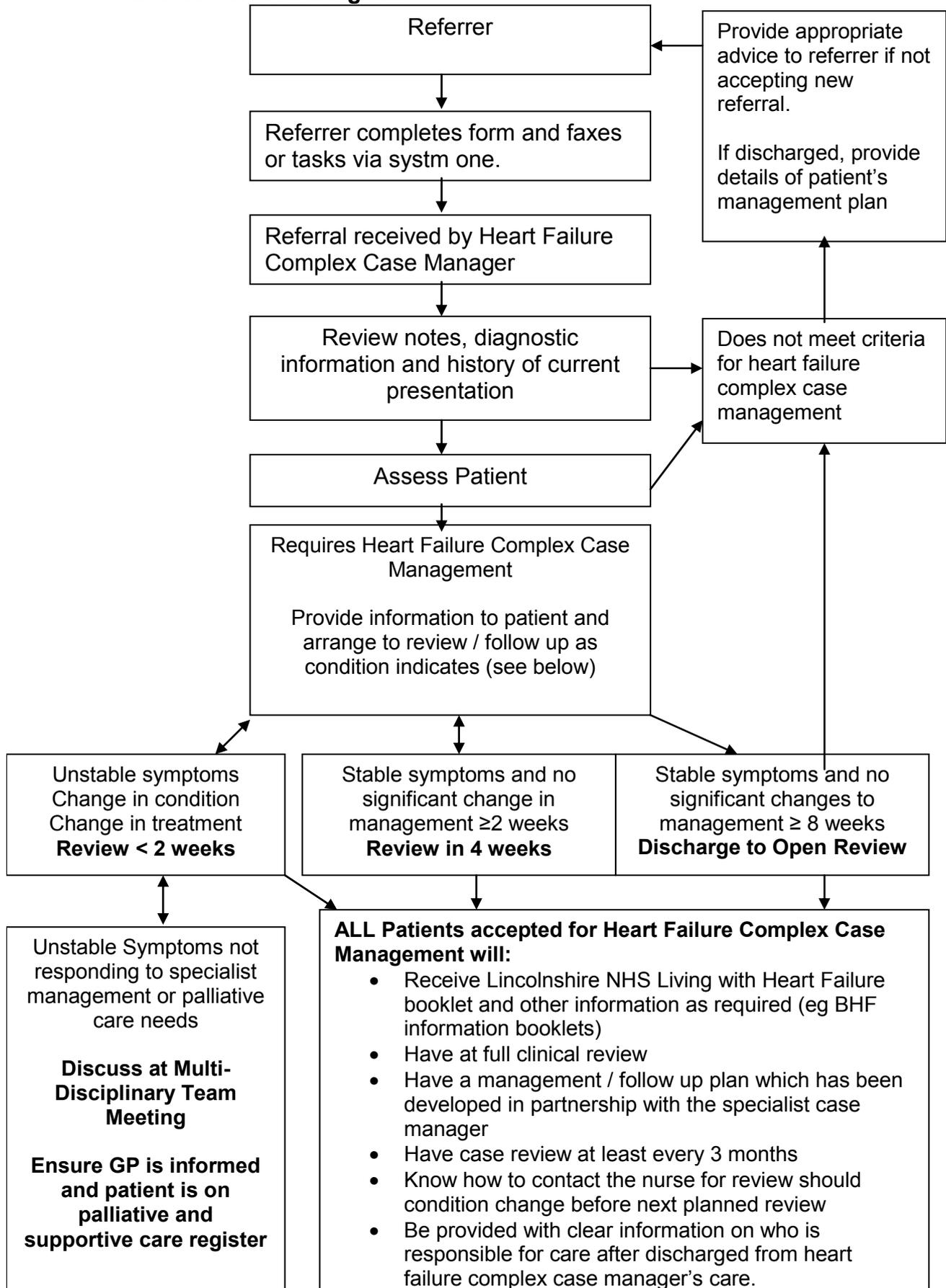
- Symptoms stable and able to self manage or be monitored by case manager / other support
- Patients, who are stable but require further optimisation of established therapies will be referred back to GP practice with a management plan to support this.
- GP Practice will be notified when patients are discharged and routine monitoring will continue via the coronary heart disease, heart failure and/or palliative and supportive care register recall systems.

All patients will be provided with a clear ongoing management plan that details of how to monitor their condition and how to seek advice /review when symptoms deteriorate / condition changes significantly.

Exceptions

- Patients unwilling to have nurse-led support
- Other immediately life threatening illness
- < 8 weeks post Acute Myocardial Infarction except via cardiologist or cardiac rehabilitation specialist nurse referral
- Patients registered with GPs outside the Lincolnshire area
- Underlying aetiology of heart failure non-cardiac e.g cor pulmonale

Heart Failure Complex Case Manager Service Information Flow Diagram



Appendix One: Community Heart Failure Complex Case Manager Referral Form

Patient's Name:		D.O.B.:	NHS No:
Address:		Past Medical History:	
Post Code:			
Tel No:			
Next Of Kin / contact details:			
Consultant:		Cardiac Dysfunction / Underlying Aetiology	
Registered GP:		<input type="checkbox"/> LVSD <input type="checkbox"/> Heart Failure Preserved Ejection Fraction <input type="checkbox"/> Significant Valve Disease <input type="checkbox"/> RVSD of cardiac origin Aetiology: (eg. Ischaemic Heart Disease)	
Practice:			
Please give details of reason for referral / presenting symptoms:			
<p>NB: Essential Criteria: Objective Evidence of Cardiac Dysfunction and Symptoms of Worsening Heart Failure of <u>cardiac origin</u>. Please attach/ fax copies of most recent echocardiogram and ECG If originals not available please provide details below.</p> <p>(Please note that an echocardiogram / angiogram is essential for an accurate diagnosis of chronic heart failure, referrals cannot be accepted without objective evidence to support diagnosis)</p>			
Other relevant information			
Name of Referrer:		Designation:	
Signature:		Date Completed:	
		Date Faxed:	

Fax Referrals to: 01427 816576

For GPs on Systm One who have echocardiography report and other referral information on patient record, please obtain consent to share record from patient and make referral via systm one.

Appendix Two Request for Deactivation on Implantable Cardioverter Defibrillator

REQUEST FOR DE ACTIVATION OF IMPLANATABLE CARDIOVERTOR DEFIBRILLATOR

Patient Name -----

Address-----

Date of Birth-----

GP details-----

Date/Time of request-----

Address patient is currently located at -----

Reason for request-----

Signature of authorising Consultant/ Physician-----

I understand the reasons for deactivating my ICD and that the decision to deactivate can be reviewed if necessary. I agree to the deactivation of my ICD.

Signature of patient/patient carer/relative-----

Date and time device deactivated-----

A note of any treatments that remain active for symptom relief?

Signature of health care professional deactivating the device

ANY OTHER COMMENTS

Appendix 3

Lincolnshire Community Health Services NHS Trust

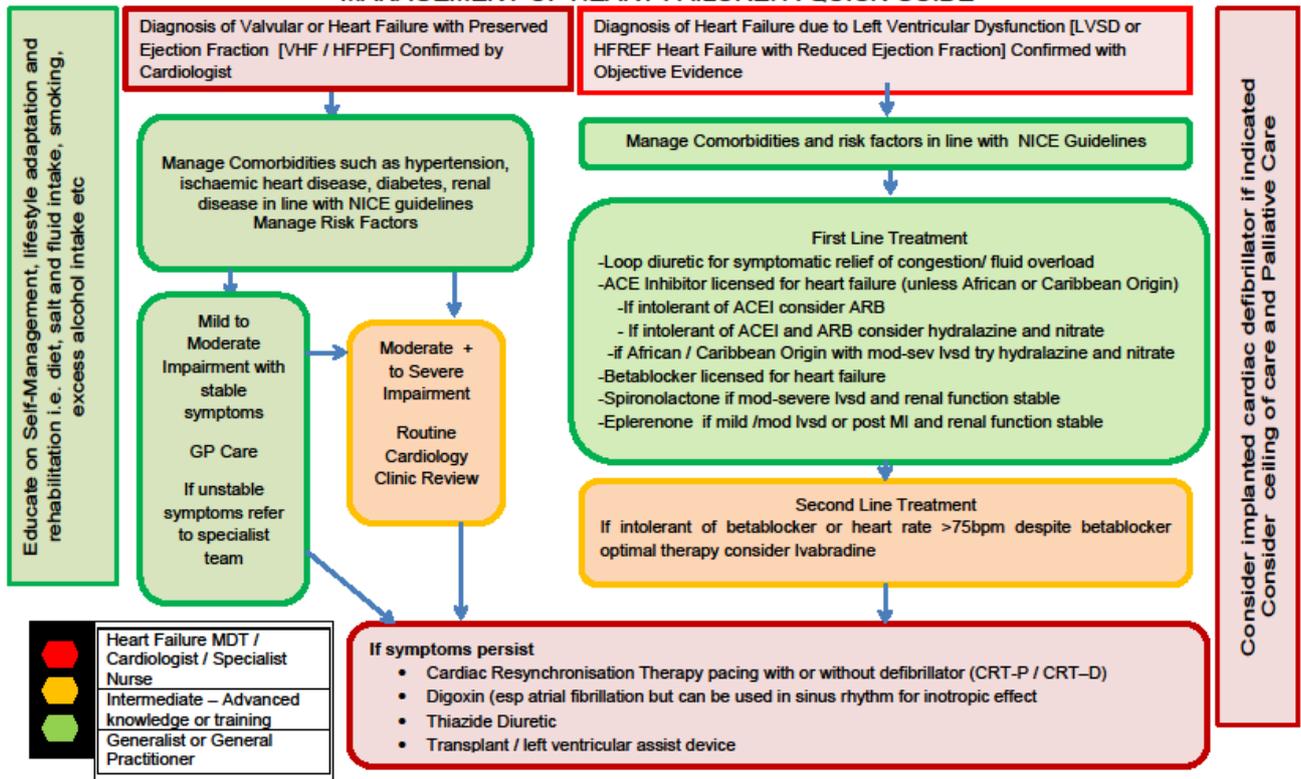
Heart Failure Self Management and Monitoring Advice

<p>Every Day</p> <p>Monitor Symptoms</p>	<ul style="list-style-type: none"> ○ Get weighed in the morning after you have emptied your bladder and before breakfast ○ Record your weight (in a diary or on a calendar can be helpful) ○ Compare your weight with yesterday's weight ○ Check your feet, ankles, legs and stomach for signs of swelling ○ Take your medication, as prescribed ○ Have a low salt diet ○ Pace activity <p>Use heart failure booklet or www.bhf.org.uk for more information</p>
<p>Stable Symptoms</p> <p>Continue Daily Monitoring</p>	<ul style="list-style-type: none"> ○ No more breathless than usual ○ Weight is stable (it may go up or down by 1 or 2 lbs but is not consistently rising or falling) ○ Swelling is no worse than yesterday ○ No chest pain
<p>Symptoms changing</p> <p>Seek Advice from Nurse or GP or 111</p> <p>My Contact Numbers:</p> <hr/> <hr/>	<ul style="list-style-type: none"> ○ Rapid weight gain or loss: more than 4-5lbs over 2 consecutive days or 1lb every day for 4 or 5 days ○ Increasing breathlessness and unable to do as much as normal ○ Need to sleep propped up more than usual ○ Need to sleep in chair ○ Swelling getting worse ○ Appetite getting less
<p>Emergencies: Symptoms start suddenly or Collapse</p> <p>CALL 999 Or 112</p>	<p>Call 999 or 112 if you have:</p> <p>SUDDEN ONSET SYMPTOMS LASTING MORE THAN 15 MINUTES:</p> <ul style="list-style-type: none"> ○ BREATHLESSNESS NOT RELIEVED BY REST ○ CHEST PAIN NOT RELIEVED BY REST and NITROLINGUAL SPRAY, IF PRESCRIBED. ○ DIZZY/ SWEATY/ CLAMMY/ FEELING SICK <p>OR Carer to call 999 or 112 IMMEDIATELY IN EVENT OF COLLAPSE</p>

Lincolnshire Community Health Services Number 2013/67 Review 2016
Issued by Health Professional in conjunction with Heart Failure Information Booklet

Appendix 4

MANAGEMENT OF HEART FAILURE: A QUICK GUIDE



Putting you first is at the heart of everything we do

Useful Weblinks/ Contacts

Organisation	Contact Information
American Heart Association	http://www.heart.org/HEARTORG/
British Cardiovascular Society	http://www.bcs.com/pages/default.asp#
British Heart Foundation	www.bhf.org.uk Tel: 0845 70 80 70
Cardiomyopathy Association	www.cardiomyopathy.org
European Society for Cardiology	www.escardio.org
East Midlands Cancer Network	http://www.eastmidlandscancernetwork.nhs.uk/ Home-Lincolnshire.aspx
National heart and lung library	www.nhlbi.nih.gov
Palliativedrugs.com	www.palliativedrugs.com
Royal College Psychiatrists	www.rcpsych.ac.uk
Patient Information Sites	www.CHFpatients.com www.patient.co.uk www.heartfailurematters.org www.arrythmiaaliance.org.uk
Advance Decision to Refuse Treatment	www.adrtnhs.co.uk
Advance Care Planning: http://www.nhs.uk/Planners/end-of-life-care/Pages/advance-statement.aspx http://www.ncpc.org.uk/sites/default/files/planning_for_your_future_updated_sept_2014%20%281%29.pdf	
Information about lasting power of attorney: https://www.gov.uk/power-of-attorney/overview	
The East Midlands Palliative Care Network have adopted the Palliative Adult Network Guidelines (PANG), 2011, providing a wealth of symptom management advice these can be accessed via: http://book.pallcare.info/	

References

- Allen, L.A., Stevenson, L.W., Grady, K.L., Goldstein, N.E., Matlock, D.D., Arnold, R.M., Cook, N.R. Felker, M., Francis, G.S., Hauptman, P.J., Havranek, E.P., Krumholz, H.M., Mancini, D., Riegel, B., and Spertus, J.A. (2012) Decision Making in Advanced Heart Failure: A Scientific Statement From the American Heart Association. Circulation. Vol. 125. pp. 1928-1952.
- American Heart Association (2008) Heart Disease and Stroke Statistics –2008Update.[online] Accessed at: <http://circ.ahajournals.org/content/117/4/e25.full> [Accessed 02/09/2012]
- Arrhythmia Alliance (2010) Implantable Cardioverter Defibrillators (ICD'S) in Dying Patients
- Baines, M. (1997) The emetic process-,pathways or emesis and the neurotransmitters involved. BMJ Vol 315 pp. 1148-1150
- Barclay, S., Momen, N., Case-Upton, S., Kuhn, I., and Smith, E. (2011) End-of-life care conversations with heart failure patients: a systematic literature review and narrative synthesis. British Journal of General Practice. [online] Available at: http://www.endoflifecareforadults.nhs.uk/assets/downloads/Barclay_Momen_HF_systematic_review_2011.pdf [Accessed 30/0812]
- Beattie J (2007) 'End of life Issues and Cardiac Device therapy' www.heart.nhs.uk
- Blue, L. and Millerick, Y. Heart Failure Liason Servive, NHS Greater Glasgow (2006) Heart Failure/Palliative Care Audit Report. Unpublished
- Blue, L., Strong, E., Davie, A.P., Murdoch, D.R., and McDonagh, T.A. (2001) Randomised controlled trial of specialist nurse intervention in heart failure. BMJ Vol.323. pp.715-18.
- Borer JS et al. Effect of ivabradine on recurrent hospitalisation for worsening heart failure in patients with chronic systolic heart failure: the SHIFT study. European Heart Journal doi: 10.1093/eurheart/ehs259
- Brannstrom, M., Brulin, C., Norberg, A., Boman, K., Strandberg, G. (2006). Living with severe chronic heart failure in palliative advanced homecare. European Journal of Cardiovascular Nursing . 4 pp 295-302.
- British Heart Foundation (BHF) (2010) Role of the British Heart Foundation heart failure palliative care specialist nurse A retrospective evaluation. London. British Heart Foundation.
- British National Formulary (2013) Accessed at www.bnf.org.uk [online] at Lincoln. June 2013
- Buckman, R.A.(2005). Breaking bad news; the S-P-I-K-E-S strategy. Community Oncology Vol.2 pp 138-142
- Chattoo, S. (2009) Extending specialist palliative care to people with heart failure: semantic, historical and practical limitations to policy guidelines. Social Science and Medicine. . 69 pp. 147-153.
- Coronary Heart Disease Collaborative (2004) Supportive and Palliative Care for Advanced Heart Failure. Available at www.heart.nhs.uk
- Crooks, V., Waller, S., Smith, T., and Hahn, T.J. (1991) The use of the Karnofsky Performance Scale in Determining Outcomes and Risk in Geriatric Outpatients. Journal of Gerontology. (46) pp. M139-M144.
- Connolly, M., Beattie, J., Walker, D., and Dancy M. (2010) End of life care in heart failure A framework for implementation. [online] Available at: <http://www.improvement.nhs.uk/LinkClick.aspx?fileticket=KBUUEsR0mms%3D&tabid=56> [Accessed 02/07/2012]

- Cubbon, R.M., Gale, C.P., Kearney, L.C., Schechter, C.B., Brooksby, W.P., Nolan, J., Fox, K.A., Rajwani, A., Baig, W., Groves, D., Barlow, P., Fischer, A.C., Batin, P.D., Kahn, M.B., Zaman, A.G., Shah, A.M., Byrne, J.A., Lindsay, S.J., Sapsford, R.J., Wheatcroft, S.B., White, K.K., and Kearney, M.T. (2011) Changing Characteristics and mode of death associated with chronic heart failure caused by left ventricular systolic dysfunction: a study across therapeutic eras. Circulation Heart Failure. Vol. 4. pp. 396-403.
- Daley, A., Matthews, C., Williams, A. (2006) Heart Failure and Palliative Care Services working in partnership: report of a new model of care. Palliative Medicine. (6) pp.593-601.
- Department for Constitutional Affairs (2007) Mental Capacity Act 2005. Code of Practice, London JSO
- Department of Health (2008) End of life Care strategy London DOH
- Department of Health (2000) National Service Framework for Coronary Heart Disease: Chapter 6. Heart Failure. London. Department of Health.
- Department of Health (2008) End of Life Care Strategy [online] Accessed at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086345.pdf Accessed 09/10/2012.
- Ducharme, A., Doyon, O., White, M., Rouleau, J.L., and Brophy, J.M. (2005) Impact of care at a multidisciplinary congestive heart failure clinic: a randomized trial. JAMC. Vol. 173. pp. 40-45.
- Doughty, R.N., Wright, S.P., Pearl, A., Walsh, H.J., Muncaster, S., Whalley, G.A., Gamble, G., and Sharpe, N. (2002) Randomized, controlled trial of integrated heart failure management. European Heart Journal. Vol. 23. pp. 139-146.
- Ekman, I., Cleland, J.G., Swedberg, K., Charlesworth, A., Metra, M., and Poole-Wilson, P.A. (2005) Symptoms in patients with heart failure are prognostic predictors: insights from COMET. Journal of Cardiac Failure. (11) pp. 288-292.
- Ellershaw J.E Wilkinson S. (2003) Care of the dying: a pathway to excellence. Oxford University Press.
- Ernest, M.A., Ross, S.E., Wittevrongel, L., Moorie, L.A., and Lin, C.T. (2004) Use of a Patient-Accessible Electronic Medical record in a Practice for Congestive Heart Failure: Patient and Physician Experiences. Journal of American Medical Information Association. (11) pp. 410-417.
- European Society of Cardiology The Task Force for the Diagnosis and Treatment of Acute and Chronic Heart Failure 2012 of the European Society of Cardiology Developed in collaboration with the Heart Failure Association (HFA) of the ESC (2012) ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure 2012 European Heart Journal Vol. 33 pp.1787-1847
- Fallon, M., and Foley, P. (2012) Rising to the challenge of palliative care for non-malignant disease Palliative Medicine Vol.26. pp. 99-100.
- General Medical Council (2010) Treatment and care towards the end of life: good practice in decision making. London. General Medical Council.
- Goodlin, S.J. (2009) Palliative care in congestive heart failure. Journal American College Cardiology. Vol. 54. pp. 386-396
- Gott, M., Barnes, S., Parker, C., Payne, S., Seamark, D., Gariballa, S., and Small, N. (2007) Dying trajectories in Heart Failure. Palliative Medicine. Vol 21. No. 2. pp.95-99.
- Gott, M., Small, N., Barnes, S., Payne, S., and Seamark, D. (2008) Older peoples views of a good death in heart failure: Implications for palliative care provision. Social Science and medicine. Vol. 67. pp 1113-1121
- Goodlin, S.J., Hauptman, P.J., Arnold, R., Grady, K., Hershberger, R.E., Kitner, J., Masoudi, F., Spertus, J., Dracup, K., Cleary, J.F., Medak, R., Crispell, K., Pina, I., Stuart, B., Whitney, C., Rector, T., Teno, J.,

and Renlund, D. (2004) Consensus Statement: Palliative and Supportive Care in Advanced Heart Failure. Journal of Cardiac Failure. 10 No.3 pp 200-209.

Haga, K., Murray, S., Reid, J., Ness, A., O'Donnell, M., Yellowlees, D., and Denvir, M. (2012) Identifying community based chronic heart failure patients in the last year of life: a comparison of the Gold Standards Framework Prognostic Indicator Guide and the Seattle Heart Failure Model. Heart. (98) pp. 579-583.

Harding, R., Selman, L., Beynon, T., Hodson, F., Coady, E., Walton, M., Gibbs, L., and Higginson, IJ. (2008) Meeting the Communication and Information Needs of Chronic Heart Failure Patients Journal of pain and Symptom Management. 36 pp 149-156.

Healthcare Commission (2007) Pushing the boundaries. Improving services for people with heart failure. [online] Accessed at: http://www.wales.nhs.uk/documents/Pushing_the_boundaries_Improving_services_for_patients_with_heart_failure_200707042319.pdf [accessed 02/07/2012]

Horne, G., and Payne, S. (2004) Removing the boundaries: palliative care for patients with heart failure. Palliative Medicine. 18 pp 291-296.

Institute for Innovation and Improvement (2009) Delivering Quality and Value Focus on: Heart Failure. Coventry. NHS Institute for Innovation and Improvement.

Jaarsma, T., Beattie, J.M., Ryder, M., Rutten, F.H., McDonagh, T., Mohacs, P., Murray, S.A., Grodzicki, T., Bergh, I., Metra, M., Ekman, I., Angermann, C., Leventhal, M., Pitsis, A., Anker, S.D., Gavazzi, A., Ponikowski, P., Dickstein, K., Delacretaz, E., Blue, L., Strasser, F., and McMurray, J. (2009) Advanced Heart Failure Study Group of the HFA of the ESC. Palliative care in heart failure: a position statement from the palliative care workshop of the Heart Failure Association of the European Society of Cardiology. European Journal of Heart Failure. Vol.11 No. 5 pp. 433-443.

Jaarsma, T. (2005) Inter-professional team approach to patients with heart failure. Heart. Vol. 91 pp. 832-838.

Johnson, M. Lehman, R. (2008) Heart Failure and Palliative Care : a team approach. Oxford. Radcliffe Publishing.

Johnson, M., Nunn, A., Hawkes, T., Stockdale, S., and Daley, A. (2012) Planning for end-of-life care in heart failure: experience of two integrated cardiology – palliative care teams. The British Journal of Cardiology. Vol. 19. No.2. pp. 71-75.

Johnson, M.J (2006) A palliative care approach for patients with heart failure. Palliative Medicine Vol.20 pp 182-185

Jordhoy, M.S., Grande, G. (2006) Living alone and dying at home: a realistic alternative? European Journal of Palliative Care. Vol 30 pp 325-8

Kasper, E.K., Gerstenblin, G., Hefter, G., Van Anden, E., Brinker, J.A., Thiermann, D.R., Terrin, M., Forman, S., and Gottlieb, S.H. (2002) A Randomised Trial of the Efficacy of Multidisciplinary Care in Heart Failure Outpatients at High Risk of Hospital Readmission. Journal of the American College of Cardiology. Vol. 39. No.3. pp. 471-480. .

Krumholz, H.M., Phillips, R.S., Hamel, M.B., Teno J.M., Bellamy, P., Broste, S.K., Califf, R.M., Vidaillet, H., Davis, R.B., Muhlaibaier, L.H., Connors, A.F., Lynn, J., and Goldman, L. (1998), Resuscitation preferences among patients with severe congestive heart failure: results from the SUPPORT Project. Circulation. 98. pp. 648–655.

Ko, H., Turner, T., Jones, C., and Hill, C. (2012) Patient held medical records for patients with chronic disease: a systematic review. Quality Safety Health Care (9) pp.1-7.

- Levenson, J.W., McCarthy, E.P., Lynn, J., Davis, R.B., and Philips, R.S. (2000) The last six months of life for patients with congestive heart failure. Journal of the American Geriatrics Society. Vol. 48. [Supplement 5] pp. 101-109.
- Lincolnshire Joint Formulary (2013) Accessed at: <http://www.lincolnshirejointformulary.nhs.uk> [online] on August 15th 2013, Lincoln
- McDonald, K., Ledwidge, M., Cahill, J., Quigley, P., Maurer, B., Travers, B., Ryder, M., Kieran, E., Timmons, L., and Ryan, E. (2002) Heart Failure management: Multidisciplinary Care has Intrinsic Benefit Above the Optimization of Medical care. Journal of Cardiac failure . Vol. 8 No. 3. pp. 142-148.
- Murdoch, DR., Love, MP., Robb, SD., McDonagh, T.A., Davie, A.P., Ford, I., Capewell, S., Murray, S., Boyd, K., and Sheikh, A. (2005) Palliative care in chronic illness BMJ. Vol. 330. pp. 611-612.
- Murray, S.A., Kendall, M., Boyd, K., and Sheik, A. (2005) Illness trajectories in palliative care. BMJ Vol. 330. pp 1007-1011.
- Muntwyler J. Abetel G. Gruner C. Follath F. (2002) One-year mortality among selected outpatients with heart failure. European Heart Journal. (23) pp1861-1866
- National Council for Palliative Care (2008). Advance Decisions to refuse treatment, a guide for the Health and Social Care Professionals. London DOH
- National Institute for Clinical Excellence (NICE) (2010) Chronic Heart Failure, Clinical Guideline 108, London. NICE.
- NICE (2011) Chronic Heart Failure Quality Standard [online] Available at: <http://publications.nice.org.uk/chronic-heart-failure-quality-standard-gs9> [Accessed 30/08/12]
- NHS Improvement – Heart (2010) Pathways for heart failure care. Making improvements in heart failure services: Final reports from the national pilot sites. [online] Accessed at: <http://system.improvement.nhs.uk/ImprovementSystem/ViewDocument.aspx?path=Cardiac%2fNational%2fWebsite%2fHeart%2fHeart%20Failure%2fPathways%20for%20Heart%20Failure.pdf> [accessed 02/07/2012]
- NHS Improvement (2012) Heart Failure – Patient Pathways Optimising Management – Multidisciplinary Working [online] Accessed at: <http://www.improvement.nhs.uk/heart/heartfailure/Home/PatientPathways/PatientPathwayMenu2/MultidisciplinaryWorking.aspx> [Accessed 06/10/2012]
- NICE TA134 June (2014) accessed at <https://www.nice.org.uk/guidance/ta314/chapter/1-Guidance> [online] Lincoln, 19th August 2015
- NICE (2007) Heart failure - cardiac resynchronisation: guidance [Online] Available at: www.nice.org.uk/TA120 [Accessed 20/09/2012]
- NHS Improvement - Heart (2011) National projects Making a difference for your heart failure patients. Leicester. NHS Improvement.
- NHS Modernisation Agency – Coronary Heart Disease Collaborative (2004) Palliative and Supportive Care in Heart Failure. London. NHS Modernisation Agency.]
- Nicholson, C. (2007) Heart Failure A Clinical Nursing Handbook. Chichester. Wiley.
- NMC (2008) The code: Standards of conduct, performance and ethics for nurses and midwives. [Online]: <http://www.nmc-uk.org/Nurses-and-midwives/The-code/The-code-in-full/> [Accessed 09/02/11]
- North and East Torkshire and Norther Lincolnshire Cardiac and Stroke Network (2011) Managing Symptoms in Patients with Heart Failure up to and Including the End of Life available at: <http://www.yorksandhumberhearts.nhs.uk>
- Palliative Adult Network Guidelines (2011) 3rd Edition available at <http://book.pallcare.info>

Palliative Care Pocketbook 3 The abridged Mid-Trent Cancer Services Network Palliative Care Guidelines available at: www.mtcn.nhs.uk

Palliative Care in End Stage Heart Failure Pocketbook (2010) Heart Failure Steering Group Nottinghamshire

Pattenden, J., and Mason, A. (2010) Better together an end of life initiative for patients with heart failure and their families. [online]:

<http://www.bhf.org.uk/plugins/PublicationsSearchResults/DownloadFile.aspx?docid=2ab20c28-291b-4894-bb5f-f9035966acb9&version=-1&title=M123S+Better+Together%3A+An+end+of+life+initiative+for+patients+with+heart+failure+and+their+families&resource=M123S> [accessed 25/08/12] .

Prognostic Indicator Guidance Gold Standards Framework, Available at:

www.goldstandardsframework.nhs.uk

Rich, M.W., Beckham, V., Wittenberg, C., Leven, C.L., Freedland, K.E., and Carney, R.M. (1995) A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. The New England Journal of Medicine. Vol. 2. pp. 1190-1195.

Remme, W.J., McMurray, J.J.V., Rauch, B., Zannad, F., Keukelaar, K., Cohen-Solal, A., Lopez-Sendon, J., Hobbs, R., Grobbee, D.E., Boccanelli, A., Cline, C., Macarie, C., Dietz, R., and Ruzylo, W. (2005) Public awareness of heart failure in Europe: first results from SHAPE. European Heart Journal. Vol. 26. pp. 2413-2421.

Rogers, A., Addington-Hall, J., McCoy, A.S.M., Edmonds, P.M., Abery, A.J., Coats, A.J.S., Simon, J., and Gibbs, R. (2001) A qualitative study of chronic heart failure patients understanding of their symptoms and drug therapy. European Journal of Heart Failure. Vol. 4. No.3. pp.283-287.

Ryder, M., Beattie, J.M., O'Hanlon, R., and McDonald, K. (2011) Multidisciplinary heart failure management and end of life care Current Opinion in Supportive and Palliative Care (5) pp.317-321.

Sica, D.A (2003) Drug absorption and the management of Congestive Heart Failure: Loop Diuretics. CHF Volume 9 No.5 pp 287-292

Tan, L/B., Bryant, S. Murray, R.G, (1988) Detrimental haemodynamic effects of cyclizine in heart failure. The Lancet Vol 8585 pp 560-1

Tsuyuki, R.T., Mckelvie, et. al. (2001) Acute Precipitants of Congestive Heart Failure Exacerbations Archives of Internal Medicine

Verma, AK., Da Silva, J.H., Kuhl, D.r. (2004) Diuretic Effects of Subcutaneous Furosemide on Healthy Volunteers: A Randomized Pilot Study. The Annals of Pharmacology. Vol.38 No.4 pp 544-549

Tebbit, P. (2007) End of life care a commissioning perspective. London. National Council for Palliative Care.

Waller, A., Girgis, A., Davidson, P.M., Newton, P.J., Lecatheelinasis, C., Macdonald, P.S., Hayward, C.S., and Currow, D.C. (2012) Facilitating Needs-Based Support and Palliative Care for People Chronic Heart Failure: Preliminary Evidence for the Acceptability, Inter-Rater Reliability, and Validity of a Needs Assessment Tool. Journal of pain and Symptom Management. pp. 1-10.

Audit/ Monitoring of policy Implementation

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individuals/ group/ committee	Frequency of monitoring/audit	Responsible individuals/ group/ committee (multidisciplinary) for review of results	Responsible individuals/ group/ committee for development of action plan	Responsible individuals/ group/ committee for monitoring of action plan
Every 2 years	Team Review	Heart Failure Nurse Team	Bi-annually	PACEF / Medicines Management Committee	Heart Failure Nurse Team with PACEF and MMC	Heart Failure Nurse Team and MMC

The implementation of the policy will be audited by the service managers through the Audit Tool attached at Appendix E of the “Guidance on Policy Development” available on the trust website

Audit is also undertaken via the Gold Standards Framework which will provide information regarding heart failure patients on this register

Implementation Strategy

The which Medicines Management Committee will ensure that the guideline is available, after approval on the LCHST website for dissemination and further supported by a submission via team brief.

In addition, individual teams will also be advised by their team leaders in respect of the guideline availability.

Training will be offered through the Trust’s Chronic Heart Failure Study Days, Palliative Care Education Forum and on request where resources allow.

Equality Analysis

Introduction

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty. It is up to each organisation to choose the most effective approach for them. This standard template is designed to help LCHS staff members to comply with the general duty.

Name of Policy/Procedure/Function*

Clinical Guidance for the Diagnosis and Management of Heart Failure Lincolnshire 2015

Equality Analysis Carried out by:

Jane Scrafton

Date:

16/08/15

Equality & Human rights Lead:

Qurban Hussain

Date:

Director\General Manager:

Sarah McKown

Date:

***In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	To provide guidance to clinicians managing the care of patients with heart failure who are on Lincolnshire GP's lists. To improve standards of evidence based care thereby improving patient care and experiences.		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? Please give details	Impacts on all health professionals in wider community who care for people with heart failure. Provides advice on supporting patients and carers. Other organizations such as St Barnabas Hospice and United Lincolnshire Hospitals NHS Trust have been involved in development of this policy and it can be used to support all healthcare staff.		
C.	Is there is any evidence that the policy/service relates to an area with known inequalities? Please give details	No		
D.	Will/Does the implementation of the policy/service result in different impacts for protected characteristics?	No		
		Yes	No	
	Disability		x	
	Sexual Orientation		x	
	Sex		x	
	Gender Reassignment		x	
	Race		x	
	Marriage/Civil Partnership		x	
	Maternity/Pregnancy		x	
	Age		x	
	Religion or Belief		x	
	Carers		x	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
Equality Analysis Carried out by:		Jane Scrafton		
Date:		16/08/2015		

Section 2 – Not Required

Equality analysis

Title:

Relevant line in:

What are the intended outcomes of this work? <i>Include outline of objectives and function aims</i>
--

Who will be affected? <i>e.g. staff, patients, service users etc</i>

Evidence <i>The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment.</i>
--

What evidence have you considered? <i>List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.</i>

Disability <i>Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.</i>

Sex <i>Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).</i>
--

Race <i>Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.</i>
--

Age <i>Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.</i>

Gender reassignment (including transgender) <i>Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.</i>

Sexual orientation <i>Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.</i>
--

Religion or belief <i>Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.</i>

Pregnancy and maternity <i>Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.</i>
--

Carers <i>Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.</i>
--

Other identified groups Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.

• Engagement and involvement

Was this work subject to the requirements of the Equality Act and the NHS Act 2006 (Duty to involve) ? (Y/N)

How have you engaged stakeholders in gathering evidence or testing the evidence available?

How have you engaged stakeholders in testing the policy or programme proposals?

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

Summary of Analysis Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

Eliminate discrimination, harassment and victimisation Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

Advance equality of opportunity Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

Promote good relations between groups Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

What is the overall impact? Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?

Addressing the impact on equalities Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.

Action planning for improvement *Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.*

Please give an outline of your next steps based on the challenges and opportunities you have identified. Include here any or all of the following, based on your assessment

● **For the record**

Name of person who carried out this assessment:

Date assessment completed:

Name of responsible Director/ General Manager:

Date assessment was signed: