The district nurse’s role in managing patients with heart failure


Summary

Heart failure is a complex disorder that affects patients and their carers in many ways. Recommendations for improving the quality of care for people with heart failure are set out in the government’s National Service Framework for Coronary Heart Disease (Department of Health (DH) 2000a) and in the guideline commissioned by the National Institute for Clinical Excellence (NICE 2003a), which describes best practice for the management of patients with heart failure. This article discusses the role of the district nurse in meeting the challenges of the NICE guideline, and suggests that district nurses are better placed than other health professionals in primary care to have a central role in delivering such care. The contribution of district nurses to the management of patients with chronic diseases and those who are terminally ill at home is also discussed. The impact of The NHS Cancer Plan (DH 2000b) on the care of cancer patients in primary care is examined briefly to ascertain whether the NICE guideline is likely to have a similar impact on the scope and capacity of district nursing.

Heart failure is a major problem for the NHS. There are at least 900,000 people living with heart failure in the UK, although the prevalence is steadily increasing as the population ages and survival, following acute cardiac disease, such as myocardial infarction, improves (Petersen et al 2002). The average age at diagnosis is 76 years, and considerable co-morbidity is common. Despite advances in therapy, many patients remain symptomatic, with breathlessness and fluid retention impairing their quality of life (Cowie 2003).

The prognosis for people with heart failure is poor: 40 per cent of people with a new diagnosis die within a year, and annual mortality drops to 10 per cent per year thereafter (Cowie et al 2000). Hanratty et al (2002), in their study of health professionals’ views on palliative care for patients with heart failure, found that predicting the illness trajectory was much harder in severe heart failure than in cancer.

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Key words

- Chronic illness
- District nursing
- Heart failure
- Standards and guidelines

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The NHS Cancer Plan

The NHS Cancer Plan (Department of Health (DH) 2000b), in common with its parent publication The NHS Plan (DH 2000c), focused on aspects of health services modernisation such as promoting the involvement and empowerment of patients. This had numerous implications for nursing and the allied health professions, not least with regard to the organisation, management and quality of care, workforce planning, education, continuing professional development, recruitment, retention, career pathways and leadership (Bullen 2002). National strategic documents for nursing and the allied health professions published around this time, such as Making a Difference (DH 1999), Meeting the Challenge (DH 2000d) and The Nursing Contribution to Cancer Care (DH 2000e), provided some guidance on how to address these issues. Two main themes have emerged from these documents, namely partnership and leadership (Bullen 2002).

District nurses have been involved in the developments that followed recommendations made in The NHS Cancer Plan (DH 2000b). Maintaining the Momentum (DH 2003) reviews the advances made since the The NHS Cancer Plan was launched in 2000, and highlights the central role of nurses in managing cancer. The report comments on the success of an education programme that is currently providing training to one in four district nurses on the delivery of palliative care to patients with cancer who choose to live and die at home. The Macmillan Gold Standards Framework (GSF) programme (Thomas K 2003a) is a seven-point plan to improve the organisation of care for dying people, which began with cancer patients but was extended to include all dying patients. Thomas K (2003a), believes the challenge for the GSF programme is to bring the best of the advances made in hospice care out into the community while still affirming the ‘speciality of the generalist’ in community care.

Interventions to address these key issues in primary care are having an impact on patient care; improving communication and proactive planning,
enabling more patients to die where they choose, and raising awareness of patients' needs while improving the sense of teamwork and morale of healthcare staff (Thomas K 2003b). The key themes contributing to the success of The NHS Cancer Plan are partnership and leadership (Bullen 2000). Will the same key themes emerge from the NICE guideline on heart failure (NICE 2003a) and can district nurses be as pivotal in its delivery?

The NICE guideline

The National Institute for Clinical Excellence (NICE) guideline on heart failure builds on the National Service Framework (NSF) for Coronary Heart Disease (CHD) (DH 2000a), which includes a short chapter on heart failure. The 'long form' of the NICE guideline (National Collaborating Centre for Chronic Conditions 2003) summarises the evidence on which the 94 recommendations in the NICE guideline are based. Eight of these recommendations are identified as 'key' in that they are considered likely to have a major impact on the outcome of care for patients. The guideline also suggests audit criteria based on the key recommendations.

Of the key recommendations, there are three that district nurses should be proactive in implementing, and in responding to the challenges that they pose. The three recommendations are:

- All patients with heart failure require monitoring, which should include: clinical assessment of functional capacity, fluid status, cardiac rhythm, and cognitive and nutritional status; review of medication; and serum urea, electrolytes and creatinine. A recommended six-monthly monitoring for stable patients with proven heart failure should be put in place.
- Patients with heart failure should be discharged from hospital only when their clinical condition is stable and a management plan is optimised. The primary care team, patient and carer must be aware of the management plan.
- Management of heart failure should be seen as a shared responsibility between the patient and healthcare professional. In implementing these recommendations, the following areas need to be addressed: education, hospital discharges, multiprofessional working, and supporting patients and carers. The challenges are inevitable; however, district nurses' knowledge of services is such that they are better able than most professionals to identify limitations and areas for improvement (Pateman 2000).

Chronic disease management

Billingham (2003) identifies that chronic disease management is an area where district nurses have successfully demonstrated their role in managing care in the community, reducing hospital admissions by as much as 50 per cent (DH 2005). In the light of the document Improving Chronic Disease Management (DH 2005) this is particularly relevant. Patients with chronic diseases, which include diabetes, arthritis, heart failure, chronic obstructive pulmonary disease, dementia and a range of disabling neurological conditions, need professionals with skills in assessment, care management, inter-agency and multidisciplinary working, home care and rehabilitation. District nurses are best placed to manage and lead the care of patients with continuing care needs, working primarily in patients’ homes to promote recovery, to sustain those with long-term health problems and to maintain health (Goodman et al 2003).

The most common reasons for referrals for district nursing input are chronic illness, terminal illness, incontinence, wound management and diabetes (Audit Commission 1999). Arnold et al (2004) argue that district nurses – who form the largest number of primary healthcare employees, seeing approximately 2.75 million people per year, and providing a high level of face-to-face contact – could, if capitalised in terms of public health, make a difference. District nurses and district nursing teams are ideally placed to adopt broader population-based public health responsibilities. Their extensive contacts, particularly with older people, provide a vital source of information, as the team, under the leadership of a district nurse, can be engaged in identifying risk, initiating and carrying out tests, and implementing treatment in older people with chronic diseases such as diabetes and heart failure.

District nurses' knowledge of heart failure

The care of patients with heart failure has become increasingly complex. The characteristics of the typical patient further complicate management. The burden of heart failure falls disproportionately on older people, who are often simultaneously afflicted with many other conditions. Gibbon (1994) suggests that district nurses find it difficult to plan for patients with long-term health needs because their training focused on cure and recovery in the short term. Patients receiving district nursing care tend to be from the older age groups: about 66 per cent of district nursing contacts are with people aged 65 or over (DH 2002). District nurses who have experience and skills in the management and nursing care of patients at home may have many patients with heart failure symptoms (diagnosed or undiagnosed) on their caseload, and up to now have not had the educational input to help manage and care for these patients. This could be due to a lack of awareness of the incidence and prevalence of heart failure in older people, and those who are housebound in the community, and its management.
Nurses are the primary providers of patient education in most healthcare settings. In a review of the literature, Albert et al (2002) found no research investigating the specific learning needs of nurses who teach and care for patients with heart failure. Although this related to nurses in the United States, it could be argued that a similar situation exists in the UK. It was found that pre-registration education tended to focus on the pathophysiology of disease processes. Nursing orientation programmes emphasise policies and procedures and the mechanics of care, including medication administration, and care delivery systems are developed on the basis of the medical model. While patients’ learning needs have begun to be studied, little is known about the learning needs of nurses who provide care to patients with heart failure.

Luker et al (2003) found that cancer patients and carers were unsure of the role of the district nurse. Many of Luker’s interviewees had a stereotypical view of the district nurse, believing that a visit was only necessary when physical and/or practical care such as wound care, giving injections and care of infusion devices was required. Much work is needed to provide the educational input to equip the district nurse with the knowledge and skills to provide holistic care to patients with heart failure. Contact by the district nursing service allows a long-term commitment to be made to those patients and their families whose needs will not be resolved immediately (Goodman 2000).

### Meeting the challenge

The case study shown in Box 1 demonstrates an unco-ordinated approach to caring for a patient with heart failure, and contrasts strikingly with a patient dying from cancer, who would have been fully informed about the diagnosis and prognosis. However, a number of initiatives offer hope that the management of patients with heart failure will improve in primary care:

- **Joint organisational working**: To establish a managed clinical cardiac network, for example, the Cheshire and Merseyside Coronary Heart Disease Collaborative and the Cheshire and Merseyside Cardiac Network. One of the aims of the joint work programme is the provision of education and training for heart failure and palliative care nurses that will be cascaded to primary care staff.
- **The development of heart failure courses with accreditation at levels two and three at local universities colleges, aimed at healthcare professionals working in primary care, including district nurses.**
- **Primary care trusts (PCTs) and district general hospitals, for example, Southport and Formby PCT, West Lancashire PCT and Southport and Ormskirk NHS Trust, working together to develop care pathways and formal discharge referral into primary care services.**

### The district nurse’s role

It is increasingly being recognised that effective management of heart failure is a multidisciplinary task in which nurses play a key role. Blue et al (2001) have demonstrated that nurse-led interventions in heart failure have a positive impact on outcome. Their involvement in predischarge patient education and home visiting, concentrating on adherence to treatment and recognising early signs of deterioration, has led to a significant reduction in readmission rates and improvement in quality of life. Lane (2002) suggests that nurses working in nursing and residential homes, can play an important part in identifying patients with undiagnosed heart failure, auditing the management plans of patients receiving heart failure medication and ensuring that patients continue to receive optimal care. As district nurses have many patients in residential homes on their caseload, this care is well within their scope of practice, given the benefits of an education programme.

Masoudi and Krumholz (2003) recommend a collaborative disease management programme that includes the careful review of medication lists. Lock (2003) demonstrates how the establishment of a specialist clinic for patients with heart failure that includes a pharmacist in the multidisciplinary team improves patients’ quality of life. The pharmacist is key to the success of the clinic, because optimal clinical management depends on patients’ concordance with medication and their understanding of its importance. As a result of positive feedback from patient satisfaction surveys, the team at North Hampshire Hospitals NHS Trust is to launch a set of guidelines, developed jointly between primary and secondary care, for the management of heart failure in primary care (Lock 2003). The team has set up several teaching sessions for GPs and practice nurses and is developing links with district nurses. Davis et al (2003) report that widespread awareness of current treatment guidelines appears to be lacking in the primary care setting, and that dedicated nursing services can be instrumental in implementing guidelines.

The prognosis for patients with chronic heart failure depends not only on pharmacological therapy but also on non-pharmacological aspects of care, which district nurses are well placed to deliver. Several studies have identified malnutrition and inadequate nutritional intake in patients with chronic heart failure (Nicol et al 2002, Pasini et al 2002, Pasini et al 2002). The British Heart Foundation (BHF) to fund a network of 76 new specialist heart failure nurse positions across England, using the New Opportunities Fund award of £9 million (BHF 2003). The network will help patients to retain independence, provide information and a link with primary and palliative care services.

**Box 1. Case study**

Mary was referred from hospital to the district nursing service for the management of a leg ulcer. The reason for her admission was given as exacerbation of congestive heart failure. No information was given with regard to her prognosis and neither the patient nor her family had any appreciation of the seriousness of her condition. There was confusion about her medication on discharge, which the family were unable to resolve. The hospital pharmacist was contacted and the district nurse was given up-to-date information with regard to the patient’s medication and condition. The patient was readmitted to hospital three days later and died.
2004). These studies propose that daily monitoring of a patient's nutritional status is essential in optimising heart failure treatment, and that the nurse needs to have appropriate and accurate measurements of nutritional status in the complex, vulnerable, heart failure patient. A screening tool – the Malnutrition Universal Screening Tool (2004) – is now available. This is a five-step flow chart designed to help nurses in hospitals, the community and care homes identify those at risk of malnutrition and plan an appropriate nutritional support programme.

Colonna et al (2003) suggest that a complete and ongoing multidisciplinary education programme for treating heart failure should include an understanding of the causes of the condition, symptoms, diet, salt and fluid restriction, drug regimen, concordance, physical and work activities, lifestyle changes, and measures of self-control. These non-pharmacological treatments can be included in the patient's programme of care and be monitored by the district nurse, who can liaise with other healthcare professionals in primary care.

The introduction of specialist heart failure nurses who would undertake a role similar to that of Macmillan nurses with cancer patients has been suggested (O'Brien et al 1998); however, the needs of heart failure patients are very different, so there needs to be a different approach. Patients dying with heart failure may have unpredictable illness trajectories; understanding and expectations will also be different from those of patients with terminal cancer. Health professionals have varying needs with regard to support and experience in the provision of palliative care for patients with heart failure (Hanratty et al 2002). In Hanratty's study, the roles of different healthcare professionals were debated, and concern was expressed that service provision for these patients could be fragmented. It was advocated that specialists in palliative medicine and cardiology should work together to support the primary care team, GPs and district nurses.

Cowie (2003) notes that the NICE guideline indicates when specialist referral is likely to be necessary – in particular, when the diagnosis is in doubt or when the patient is unwell or failing to respond to standard therapy. However, a 'specialist' does not necessarily mean a consultant cardiologist, but any healthcare professional with special knowledge and experience in the diagnosis and management of patients with heart failure. This could be a GP with a special interest, a specialist nurse or a district nurse with the relevant experience and education. The newly appointed heart failure nurses backed by the BHF are ideally placed to act as co-ordinators of services, as well as supporting the GP and district nurse in primary care, perhaps using a model similar to that which the Macmillan service uses.

Sharing responsibility

The goal, as detailed in the NICE (2003a) guideline, is that patients with heart failure should be discharged only when their clinical condition is stable and a management plan has been optimised. Hanratty et al (2002), whose study focused on doctor's perceptions of palliative care for patients with heart failure, found that most doctors were enthusiastic about developing the role of the nurse in terminal heart failure. They described an often superior ability of the nurse to liaise with other specialties and to communicate with patients. The problem of balancing a desire to maintain ownership of an area of care with existing heavy workloads is common to GPs and district nurses.

The need to improve communication between healthcare professionals and patients and their families was highlighted by the patient representatives on the NICE guideline group, and was corroborated by the patient focus group organised by the Patient Involvement Unit of NICE (Thomas V 2003). The term 'heart failure' is not often used in clinical practice, leaving all concerned to use the type of euphemisms that were common in cancer practice 30 years ago (Cowie 2003). The uncertain prognosis of heart failure means that medical staff are concerned about the impact on patients of giving bad news too soon, fearing that patients will lose faith in professional carers. An increased openness about prognosis is associated with growing demands on health professionals and patients who may need psychological support. Medical staff often portray themselves as unrealistic prognosticators, admitting that they accept the poor outlook late in the illness. Nurses, patients and carers, it is suggested, are more realistic predictors (Hanratty et al 2002). The public version of the NICE guideline – Management of Heart Failure (NICE 2003b) – should encourage better understanding of the treatment, management and standards that can be expected with regard to heart failure. However, much work needs to be done if patients and carers are to feel supported. From the patient's viewpoint, a high-quality service that is easily accessible is vital, with a clear management plan being communicated to patients and carers.

Partnership and leadership

Partnership and leadership will be integral to the success of the NICE (2003a) guideline on heart failure. Health Secretary John Reid, speaking to nurse leaders at a chief nursing officers' conference, explained that he wanted to place caring at the centre of NHS values and to encourage a new generation of entrepreneurial nurses who are willing to take risks, take the initiative and create and implement new ideas (DH 2004). His vision for the future

REFERENCES

includes nurses winning contracts to provide services under the new General Medical Services contract for GPs. Frontline nurses will have opportunities to work in new ways and may wish to extend their current role and range of responsibilities to include chronic disease management (NHS Confederation and the National Primary and Care Trust Development Programme 2003).

In debating the gatekeeping role within primary care services, Bigger (2004) believes that primary care nurses are best placed to shape the future of health services provision. Nurses follow protocols, consider practical as well as medical solutions to problems, and are fundamentally patient-centred rather than problem-centred. Potentially, through adoption of the gatekeeping role, district nurses could become the main co-ordinators of care for patients with chronic diseases such as heart failure. The rational use of nursing skills would enable GPs to focus on primary prevention, diagnosis and management of acute illness.

Conclusion

The increased incidence of a chronic disease such as heart failure presents a huge challenge to health professionals. Already highly prevalent in the ageing population, heart failure is likely to increase in prevalence over the coming years. Much of the onus of caring for the increased numbers of patients will fall to health professionals in primary care, especially district nurses.

NICE is not charged with implementing the guideline, but states that it is up to local health communities to review their existing service provision for the management of patients with heart failure against its recommendations as local delivery plans are developed. There is a genuine willingness among health professionals to improve the standards of care for heart failure. With the support of a specialist nurse working across primary and secondary care, the district nurse could be pivotal in reducing hospital admissions by ensuring regular and effective patient contact as recommended by the guideline.

An educational programme developed especially for nurses in primary care, to provide training on the care of the patient living at home with heart failure, could reasonably expect to be as successful as the one developed in response to The NHS Cancer Plan (DH 2000b). District nurses are ideally placed and experienced in liaising with other specialties to ensure that the patient in primary care gets the best service. If the educational initiatives organised by local cardiac networks, university colleges and PCTs provide district nurses with the support they require, they will have the confidence to lobby for improved and speedier discharge of patients into the community. The challenge that Thomas K (2003a) identified with regard to improving cancer care and bringing the best of the advances made in hospice care out into the community, while still affirming the ‘speciality of the generalist’ in the community, is just as relevant following the NSF for Coronary Heart Disease (DH 2000a) and the NICE guideline on heart failure (NICE 2003a), and is one that district nurses are more than able to meet.


Thomas K (2003b) In search of a good death. Primary healthcare teams in new framework for better care of the dying at home. (Letter to the editor.) British Medical Journal 327, 7408, 223.