Nurse-led management of heart failure outpatients

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Since its establishment in 1999, the Heart Failure Outpatient Clinic (at Department of Vascular Diseases, University Medical Center in Ljubljana, Slovenia) supplemented cardiovascular diagnostic assessment, therapeutic management and follow-up with a structured and comprehensive nurse-led heart failure education program aimed at empowering outpatients with chronic heart failure.

In 2012, a pilot program of nurse-led heart failure management (including education, but also follow-up and heart failure medication optimization with up titration of baseline therapy and adjustment of diuretic dosage) was started. The pilot program of nurse-lead heart failure management consisted of at least 4 visits every 2–3 weeks and included 100 patients (mean age 80±6 years, 39% female); the program accomplished an increase in patients taking optimal heart failure medication (i.e. 38% on maximal ACE inhibitor dose as compared to 18% in the usual care group, p=0.002) and a decrease in patients with congestion/weight gain (12 vs. 42% in the usual care group, p=0.001).

From 2015, the nurse-led heart failure management program was implemented as the standard of care at the Heart Failure Outpatient Clinic (3 days/week – once a week for first visits/intake and twice a week for follow-up visits). At first visit/intake, patients referred for evaluation of suspected heart failure undergo thorough cardiovascular examination (including cardiologist assessment, echocardiography, blood analysis, 6-minute walk test) and if heart failure is confirmed, appropriate therapy is initiated by the managing cardiologist and education is carried out by a dedicated nurse. A structured and comprehensive education program addresses heart failure natural history, signs/symptoms, precipitating factors and signs of impending worsening, management, diuretic therapy, lifestyle intervention etc. Also, follow-up appointments with managing nurse are arranged and patients are followed at 2–3 weeks interval, with basic check-up (symptoms, adherence to medication, blood pressure, heart rate, body weight) and therapy dosage optimization (up titration of ACE inhibitors/ARBs, beta blockers, MRAs and sacubitril/valsartan, and dose adjustment of diuretic therapy) under supervision and in consultation with managing cardiologist.

Nurse-led heart failure management programs improve outpatients follow-up yielding to better medication adherence and better optimization of both, diuretic therapy and lifesaving heart failure medication (thus possibly decreasing hospitalization rates and even mortality). Also, continuous education through frequent follow-up visits enables better outpatient empowerment and possibly improves quality of life.

LITERATURE


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