Heart Failure post discharge – protocol WMAHSN-29

Purpose

- To enable patients who have been admitted with heart failure (prime reason) or another long term condition (heart failure secondary condition) to be discharged from hospital as soon as it is clinically safe to do so.
- To provide a mechanism for feeding back to responsible clinician(s) how the patient's condition is progressing.
- To enable responsible clinician(s) and patient to take action if there are early symptoms or signs of deterioration, to prevent readmission to hospital whenever possible.
- To help patient understand heart failure and promote self management of their condition via their shared management plan.

Setting:

Acute /community heart failure nurse setting interface, where the responsible clinician and the community heart failure nurse team monitors responses that patient texts to Flo website and advises action where necessary.

Selection of patients

- Patients who have been admitted with heart failure (prime reason) or another long term condition (heart failure secondary condition) who are in-patients and whose planned hospital discharge is imminent.

Expected outcomes:

1 Changes in healthcare usage:
- Fewer avoidable admissions to hospital or attendances at A&E.

2 Patient empowerment:
- Improved understanding and management of their heart failure condition.

3 Improved clinical outcomes:
- Proactive prevention of deterioration improves control of heart failure, so less breathless, higher quality of life. .

4 Popularity of Flo:
- Patients find Flo messages helpful and reassuring
- Clinicians find Flo enables remote monitoring of a patient, so they can safely be discharged or treated appropriately outside of hospital.

5 Cost effectiveness:
- Reduced length of stay in hospital and less likelihood of readmission.

6 Other:
- Information gathered by 'Flo' will aid management decisions.

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Protocol summary

– 56 day protocol with outcomes measured at time 0, and 31 days.

- Patient is enrolled on the 'Flo' tele-healthcare system by their clinician on the ward. On discharge into the community the community heart failure nurse takes responsibility for monitoring the patient via Flo and advising patient on actions.
- The patient and clinician agree a shared management plan with appropriate review date(s).
- Three times a week, the patient receives text messages asking them to compare their wellbeing now with that pre-admission and send their response to Flo.
- On three other days of the week, patients are asked to rate their symptoms against a traffic-light chart detailing symptoms of heart failure, together with advice about management. Patients are asked to text whether they are in the green, amber or red categories.
- Evaluation (optional) – capture of healthcare usage, patient experience at end of 56 days.

Patient:

- Signs contract, agreeing to respond to messages from Flo.
- Signs a consent form accepting that they remain responsible for their health, and understanding that messages are sent to an inanimate machine.
- Responds to daily questions about improvements in symptoms

Clinicians (in hospital then hand over to community heart failure nurse team):

- The hospital based clinician agrees a shared management plan with the patient, which includes the use of Flo.
- Explains to the patient that readings are sent to an inanimate machine which is not monitored continuously, and obtains their signed consent form which states that the patient remains responsible for their own health.
- Lends patient sphygmomanometer and teaches patient to take reliable BP readings.
- Obtains patient's signed agreement to respond to Flo.
- Enrols patient on Flo by using the patient's current mobile phone number and NHS number, then selecting the appropriate service for them.
- On discharge from hospital, the clinician agrees with the community heart failure nurse team and asks them to include the patient on their Flo list.
- The community heart failure nurse then enrols the patient, and observes the daily feedback from the patient about their condition (with hospital clinician remaining as easily contactable and providing clinical advice to the community heart failure nurse).
- When patient stable (or when Flo programme finishes at 56 days), the community heart failure nurse 'stops' the Flo programme for the patient. The responsible GP might choose to continue the remote delivery of care via Flo and a general practice heart failure protocol that aims to titrate up medication (ACEI or betablockers) if they think that the patient's condition can still potentially be improved by doing so.

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Baseline

Day 0

11.02am

Hi, I'm Flo. Over the next month, I'll be asking how you are Thanks.

11.05 am (DIARY):

Please text : HEA 3 if you feel better now than the best you have been in the last 2 months; HEA 2 if you feel the same, or HEA 1 if you are worse. Thanks, Flo.

Thank you for letting me know how you are today. Take care, Flo.

Wellness question

Monday, Wednesday, Friday at 11.02am (DIARY)

Please text : HEA 3 if you feel better now than you did two days ago; HEA 2 if you feel the same, or HEA 1 if you are worse. Thanks, Flo.

1 hour later if the patient has not replied to the first message:

Hi, you've not said how you are today. Text: HEA 3 if you're better than two days ago; HEA 2 if you're the same, or HEA 1 if you feel worse. Thanks, Flo.60-200*: Your heart rate is fine today. Take care, Flo*

Thank you for letting me know how you are today. Take care, Flo

Heart Failure Chart question

Tuesday, Thursday, Saturday at 10:00am (Heart Failure Q)**:**

Are you in green, amber, or red on your chart today? Please text CHART 3 for green, CHART 2 for amber, or CHART 1 for red. Thanks, Flo.

1 hour later if the patient has not replied to the first message:
Hi. You haven't said if you are in green, amber, or red on your chart today. Please text CHART3 for green, CHART 2 for amber, or CHART 1 for red. Thanks, Flo.

Please see your chart to understand what to do about it. Thanks, Flo.

Patient Experience Questions

(xEvalQ1) Day 56 at 12:00pm

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Hi, please text CON 1, if you have felt more confident about managing your health since using Flo, or CON 2 if you have not. Thank you.

Thank you for letting me know if you found the text messaging service helpful. Take care, Flo.

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