A UNIT BASED APPROACH TO ACUTE HEART FAILURE MANAGEMENT

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Background/Significance: Appropriate management of heart failure (HF) requires complex treatment regimens and patient participation. Research has demonstrated that establishing multidisciplinary teams to provide evidence based care, patient education, smooth care transitions, and assuring a follow up appointment with the patient’s physician is obtained before discharge, can lead to reduced readmission rates and cost savings (McAlister, et al. (2001, American Heart Association, 2009).

Purpose: To ensure all hospitalized heart failure patients receive improved unit based care, grounded in the most current evidence available, have a transitional plan in place at discharge, and to reduce the hospital length of stay and readmission rates for HF.

Population: All patients admitted to the hospital with HF.

Setting: A large quaternary care, urban medical center in the Midwest.

Method: A multidisciplinary group, co-led by the chief nurse executive and a gerontological Clinical Nurse Specialist, was formed as one of three subgroups designed to improve the care of HF patients. The three committees, outpatient/emergency department, inpatient, and transitions (visiting nurses, community based case management), examined the HF literature and identified opportunities for staff education, patient education, and better use of resources. Staff and patient education materials along with communication pathways, both electronic and traditional, were developed by each committee. Timing and patient assessment parameters for all disciplines were achieved through contemplative dialogue and consensus. Each RN, on the primary and back-up unit designated for HF patients, performed a HF case review with the unit CNS to determine competency. Most RNs needed education. Four hours of class and on-line education were created to establish or maintain RN competency, taught by experts within the interdisciplinary care team.

Outcomes: Preliminary data for the primary unit demonstrated improvement in patient satisfaction related to discharge and medication teaching. Hospital HF readmissions have decreased by 2%. Mobility, nutrition, medical and social needs, the patient’s disease comprehension, self-care, and post discharge needs are assessed and identified by all disciplines within 24 hours of admission. For the first time the patient assessment can be communicated directly through the electronic health record (EHR) from the inpatient setting to the outpatient or community setting providers. An EHR HF order set was developed. Patient education materials utilizing teach back methodology, electronic programs and on-line tools (EMMI) started during the inpatient admission, now continue to the outpatient or community setting by the case manager or visiting nurse.

Conclusions/Implications: Early results indicate that a unit based approach to HF management with emphasis on nursing expertise, patient education, and smooth transitions from inpatient to outpatient settings can positively impact patient satisfaction and readmission rates.