

The role of Heart Failure Specialist Pharmacist as part of a new secondary care based multidisciplinary team

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Northampton?



Traditional Heart Failure Management

- Diagnosis confirmed by Cardiology
- Periodic review by Cardiology team
- Some areas – Primary care nurses
- Interim management by
 - GP ?
 - Cardiology team ?

Weaknesses of traditional system

- Large use of NHS resources
- Failure to reach therapeutic targets e.g. dose optimisation
- Lack of structured support for patients
- Recurrent admissions / readmissions
- Poor concordance with therapy
- Poor symptom control
- High mortality

Drivers for Change

- National Service Framework Coronary Heart Disease – Chapter 6 Heart Failure
- NICE guideline – CG005 – Management of chronic heart failure in adults in primary and secondary care
- Our health, our care, our say
- Foundation Trust Application
- Evidence from nurse led services
- Healthcare commission review of heart failure / acute hospitals portfolio
- Non-medical prescribing

NSF / NICE guidance

- Define standards of care and aims of management
- Suggests service models including primary, interface, secondary care using multidisciplinary teams
- Identification of those at risk
- Evidence based management including non-drug treatment
- Audit
- Assessment / treatment algorithms

Our health, our care, our say

- Government White paper
- More support for patients with long term needs
- Practice based commissioning, payment by results, QOF
- Shifting resources into prevention
- Care closer to people's homes

Role of the British Heart Foundation

- BHF – registered charity – funds research into cardiovascular disease and health care professionals
- Provides funding of Specialist Nurse and Pharmacist for 3 years
- BHF funds over 360 nurses, 2 pharmacists
- 4 study days per year
- Individual training budget

Multidisciplinary service

- Consultant Cardiologists and teams
- GPs with special interest (GPwSI)
- Specialist Nurse
- Specialist Pharmacist
- Administrative support
- Others e.g. physiotherapy, dietitians as required

Aims of the service

- To improve the management of patients with acute and chronic heart failure
- To improve the quality of life of patients with chronic heart failure and support their carers
- To avoid unnecessary hospital admission and reduce length of stay
- To facilitate admission where this is appropriate
- To act as a resource for health care professionals in both primary and secondary care
- To provide seamless care between primary and secondary care

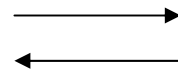
How the MDT works

- Patients diagnosed by independent prescriber
- Referred to Heart Failure team for follow up and management
- Clinical management plan agreed for all patients referred
 - On-going assessment and examination, further investigations, changes in drug therapy, liaison with primary care
- Refer back to independent prescriber if any change in diagnosis, complications or annual review due
 - On-going MDT review as required

Clinical Roles

Specialist Pharmacist

- Medication Histories
- Medication review
- Optimising dosing
- Tailoring therapy
- Monitoring response to therapy
- Dealing with adverse effects
- Patient/carer information
- Primary care liaison



Specialist Nurse

- Initial assessment / class
- Tests and investigations
- Physical examination
- Educating patients on pathology
- Lifestyle advice
- Social issues / Psychology
- Patient/carer liaison
- Primary care liaison

Service design

- In-patient role – daily visits to IP with HF, advisory role to responsible teams, OP FU if required
- Out-patient role – 3 clinic sessions per week, 2 hospital based
- Ongoing telephone / e-mail support
- Audit

Supplementary Prescribing in Practice

- Good working relationship with IP vital – need confidence in each other
- SP has degree of choice within CMP
- Access to common clinical record desirable
- Majority are recommendations to GP

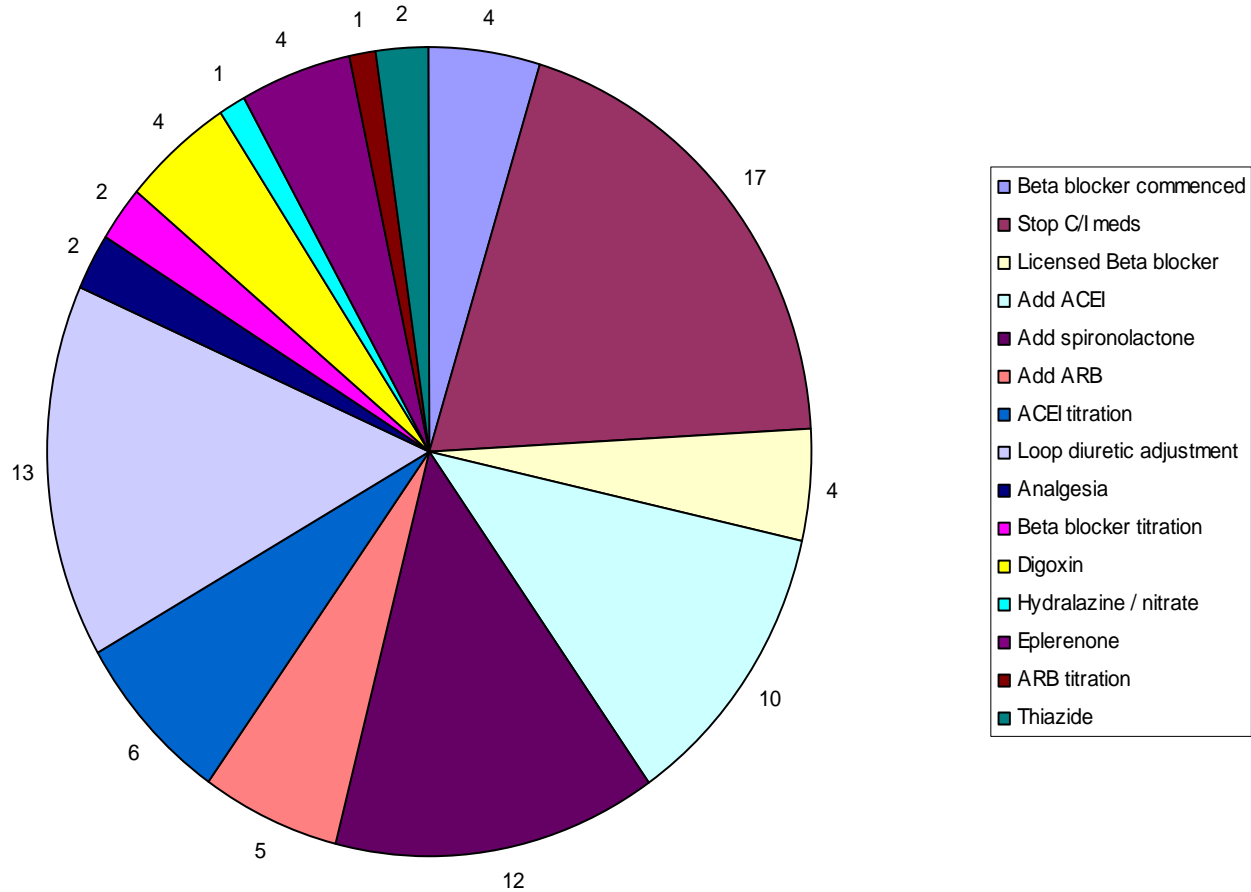
The Clinical Management Plan

- Allows for judgement of SP within plan
- Includes
 - Symptomatic management
 - Improving outcomes
 - Criteria for referral back to IP
- Treatment plan and management in line with referral
- Regular review of plan with evidence base

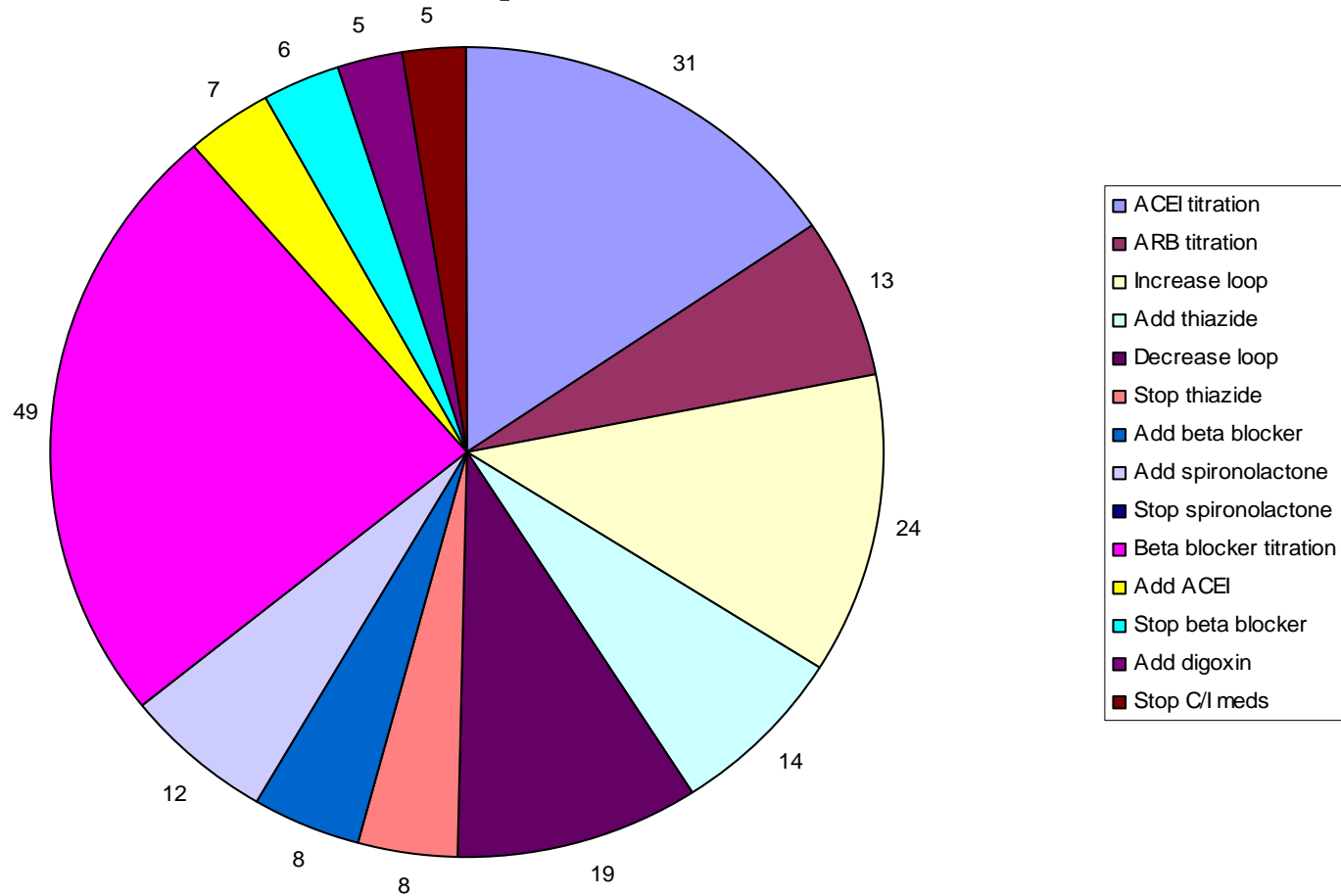
Impact on patient care

- Increases capacity
- More intensive follow up
- Appropriate investigations
- Dose optimisation of key medicines
- Close monitoring of therapy
- Complimentary expertise of MDT
- Improved information for patients and their carers
- Increased support for patients and their carers
- Improved patient satisfaction
- Reduced hospital admissions, reduced length of stay, improved quality of life

Medicine related interventions for In patients



Medicine related interventions for Out patients



Diagnostic clinic

- With cardiologist, 2 GPwSIs, Specialist Nurse
- Delivery in 2 primary care settings
- Pts referred by GPs
- Echo performed by GPwSI
- Diagnosis and treatment plan by GPwSI
- Follow up by pharmacist and HFN
- Regular MDT review with cardiologist

Improving medication safety

- IP / OP interventions – stopping C/I meds
- Dose optimisation
- Education of patient
- Regular therapeutic review

Professional Challenges and Development

- IP Responsible for setting parameters of CMP
- SP has discretion within this
- Ordering and interpretation of tests – e.g. 24hr ECG, 24hr BP monitors, ECG, ECHO
- Consultation skills
- Physical examination
- Dealing with sensitive issues

Service development

- Conversion to IP
- Primary care HFNS
- What to do with those we don't see?
- How to identify in-patients – BNP?
- Open service to GPs

Outstanding issues!

