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Title: Development of Nurse Led Models of Care for People with Heart Failure – a descriptive study.

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Introduction:

In Canterbury, there are 20-30 admissions per week on average for patients with a primary diagnosis of HF, and inconsistencies with usual care. A sub-section of the Canterbury HF Steering group therefore designed a primary health care led model for HF to combat this.

Aim:

A qualitative research project was then designed to gauge the support from practice nurses for the practice nurse led model of care for HF in Canterbury, including the benefits and barriers to its implementation.

Impact:

This study could lead to a widespread nurse led approach for managing HF that could help to address the significant volumes of admissions and readmissions to hospital for HF in Canterbury, as well as inconsistencies in care throughout primary care.

Method:

Practice nurses from Canterbury were recruited via email using a flyer, to attend two focus groups (n=11). Before attending they were sent an outline of the primary care nurse led HF model and two research articles about HF. They were audio-recorded using a dictaphone and transcribed verbatim. Thematic content analysis was then used to categorise data, and validated using peer group researchers.

Results:

Benefits to the patient and primary care team

Improved patient care

Participants believed the model would “reinforce that bit of education” (P3) and “increase their understanding of the condition” (P2) by enabling long-term contact with the patient. In addition, it “seemed to tick all of the boxes about patient centred care” (P7) in an accessible, familiar environment, to develop “rapport” so “that relationship and that trust builds between you and the patient” which “has a huge impact on how motivated they are” (P2).

Through having frequent contact with the patient “it will just help them open up a bit more” (P5) so you “will catch things a bit earlier” (P5) and improve long term management of their condition. “Better support” also means patients are “less likely to slip through the system” (P4) and encourages self-management which has other flow on effects such as “help them stay out of hospital.” (P11)

Increased efficiency and standardisation of care

Many benefits were identified for the general practice team, such as making use of nurse skills and knowledge when managing HF patients, which “will free up GP time.” (P1) This model also provides a framework to work with that is “clear and set out” and “realistic” with “very specific things to do at each stage”, making it easier to learn and make a new task seem less ‘daunting’.

It also allows a standardised approach so there is “*good continuity throughout the practices and patients leaving between practices*” (P5), including rural centres.

Barriers to implementation

Local level barriers

Most participants felt they lacked the time and energy to initiate this model without extra support, particularly for new practice nurse’s or a practice nurse in a smaller practice. They identified that additional support, or a lead nurse in the practice to initiate the model, would help as “*it’s just easier if one person kind of your go to person.*” (P8).

A few participants felt that access to discharge letters for applicable patients would allow them to better manage their patients and identify patients which require follow-up. Many also identified that it would be beneficial “*to have some of those screening templates more cardiac specific*” (P6), as it “*will actually support that move, to make it really simple.*” (P1).

Systems level barriers

Classifications are essential for carrying out a query build of patients within a general practice, to identify patients accurately, but these were described as “*messy*” (P8), and to improve them it would require a lot of time and resources.

Practice nurse education around HF management and this model would also be required. In the past, funding has been used to put practice nurses through an ARA level 7 paper, however the participants said they were unable to attend due to timing. Knowledge on funding streams was also a barrier identified by the practice nurses, and they felt they needed more education to maximise existing funding for this model.

Funding access

Socio-economic difficulties can be a huge barrier for patients accessing care, therefore the cost to the patient must be considered when implementing this model:

“we’re just \$2 a visit, but even then we still get some people who state ‘can I still come I haven’t got any money.’” -P11

Due to the ‘fee for service’ funding model, participants felt they were not able to see their patients regularly enough to provide good management, including those participants who had a large knowledge on current available funding streams, and maximised their use. This suggests that funding model options may need to be built within the nurse led model to allow practices to implement it without constraints, in addition to maximising use of existing funding.

Conclusion:

This research gives insight into the feasibility for practice nurses to implement this practice nurse led model, and the benefits it would provide to the patient. The results suggest this model could aid in improving self-management of HF, reduce hospital admissions, and improve the inconsistencies in primary care for HF management.

The model will be revised, with consideration of the barriers identified, to enable a pilot study with 2-3 interested practices. If successful, it could lead to a widespread nurse led approach to managing HF that could help people stay well in their homes and communities.