HEART FAILURE

CRD-1 Protocol and Pathway - Cardiology Specialty (14/03/2011)

Patient presents

PATIENT HISTORY

1. Is this heart failure?
2. What underlying condition does this patient have that would make this diagnosis possible
3. Is patient acutely ill and does he need urgent admission?
4. Does he need an urgent outpatient assessment?

INITIAL MANAGEMENT IN PRIMARY CARE

1. Detailed history
2. Thorough examination for signs of heart failure, and potential causes.
3. Consideration of other causes of shortness of breath, tiredness and oedema?
4. Routine 12 lead ECG – If abnormal heart failure possible. If completely normal heart failure less likely. (If help needed for ECG interpretation required – contact intermediate – community service – GPwSI – or just attach with referral)
5. Consider BNP testing if available. If completely normal HF ruled out (see MOP; NICE etc for guidance).
6. Before referral – get baseline U&E, FBC, LFTs, TFT and ECG.
7. Referral letter must include – A). Detailed reasons for suspecting heart failure; B). All relevant Past History with dates: C). Results of basic Investigations done. D). Current updated medication list.
8. Start on diuretics for symptomatic relief if indicated

IF NO IMPROVEMENT OR MORE COMPLEX CARE NEEDED, THEN:

1. As above AND:
2. Request a full Echocardiogram and ECG if not already done
3. If systolic dysfunction heart failure confirmed start on treatment with ACE inhibitors and Beta Blockers (if no contraindications) and titrate upwards gradually as tolerated.
4. Seek help if not getting better.
5. Establish reasons for heart failure.
6. Seek help if indicated for further investigations and treatment.
7. Consider Biventricular pacing or revascularisation and refer to secondary / tertiary care if indicated

ONWARD REFERRAL

Key

Patient presents

GP level intervention

Non-Primary Care

Red flag