Kent Surrey Sussex Academic Health Science Network

Heart Failure Collaborative

Sussex Health and Care Partnership

Primary Care

Heart Failure Diagnostic and Treatment Pathways

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Edited for Primary Care by Sussex Health and Care Partnership – Heart Failure Sub-group in collaboration with KSS Heart Failure Collaborative Steering Group and Kent Surrey Sussex Academic Health Science Network.

Endorsed by British Heart Foundation (BHF), Primary Care Cardiovascular Society (PCCS), Pumping Marvellous Foundation

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Primary Care Cardiovascular Society

Driving primary care to deliver the best in cardiovascular health

Pumping Marvellous

The heart failure charity

Introduction

Heart failure affects nearly a million people across the UK. It is a life-limiting condition that too often causes emergency hospital admissions, poor quality of life and ultimately early death. But it is possible to live well with heart failure and our Heart Failure pathways have been standardised for use in Primary Care services to facilitate referrals to diagnostic and heart failure treatment services.

Despite the Covid-19 pandemic, the acute and community Heart Failure services remain open and existing referral processes should be followed, for both diagnostic tests and referring patients with a confirmed diagnosis of heart failure who are unstable and/or at risk of hospital admission to specialist heart failure services for review.

Patients with CVD risk factors may have experienced symptoms of MI, stroke, transient ischaemic attack (TIA) or **heart failure** during the pandemic and not reported these. Consider asking patients whether they have experienced symptoms of these conditions during the pandemic and manage accordingly.

Early diagnosis of people with heart failure, with prompt access to integrated services and specialist care, can help to cut emergency admissions, improve quality of life and give people the opportunity to live well for longer.

This document is a consolidation of the heart failure diagnostic and treatment pathways:

- If suspected unconfirmed heart failure then use the diagnostic pathway
- If heart failure already confirmed use treatment pathway with echo report attached.
- If referral is for an exacerbation of known heart failure, consider referral back to the heart failure nurse where it meets their criteria or otherwise hospital or community heart failure specialist clinic.

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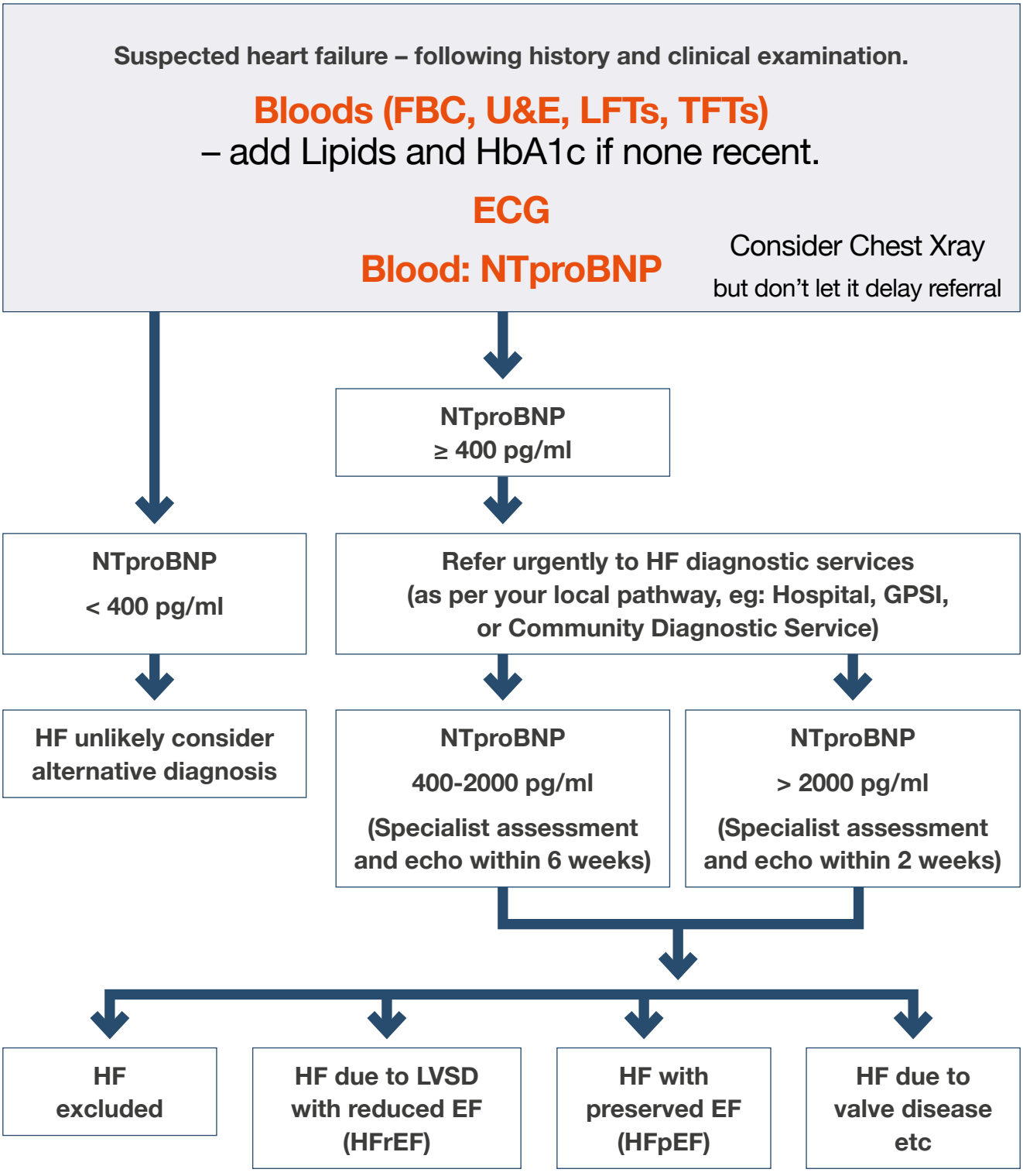
Suspected new diagnosis of heart failure in primary care



Expected treatment pathway for HFpEF in Primary Care

Confirmed diagnosis of HFpEF

Consider referral to heart failure nursing team – if patient unstable and symptomatic with heart failure requiring complex diuretic management or at risk of hospital admission with primary cause heart failure. *GP to check referral criteria for local Community HF nursing service if commissioned.

There is no evidence of prognostic benefit from ACE-I / ARB or beta-blockers but may be prescribed to treat co-morbidities.

Prescribe diuretics to relieve congestion / peripheral oedema

Provide advice on self-management including daily weights and variable diuretic dosing

Consider spironolactone if diuretic resistance or hypokalaemia

Primary Care to identify, treat, optimise and manage other co-morbidities:

Atrial fibrillation

Hypertension

IHD

Diabetes

CKD

Primary Care: HFpEF stable – Once diuretic dose is stable and symptoms improved move to heart failure review for HFpEF (including U&E at least 6 monthly).

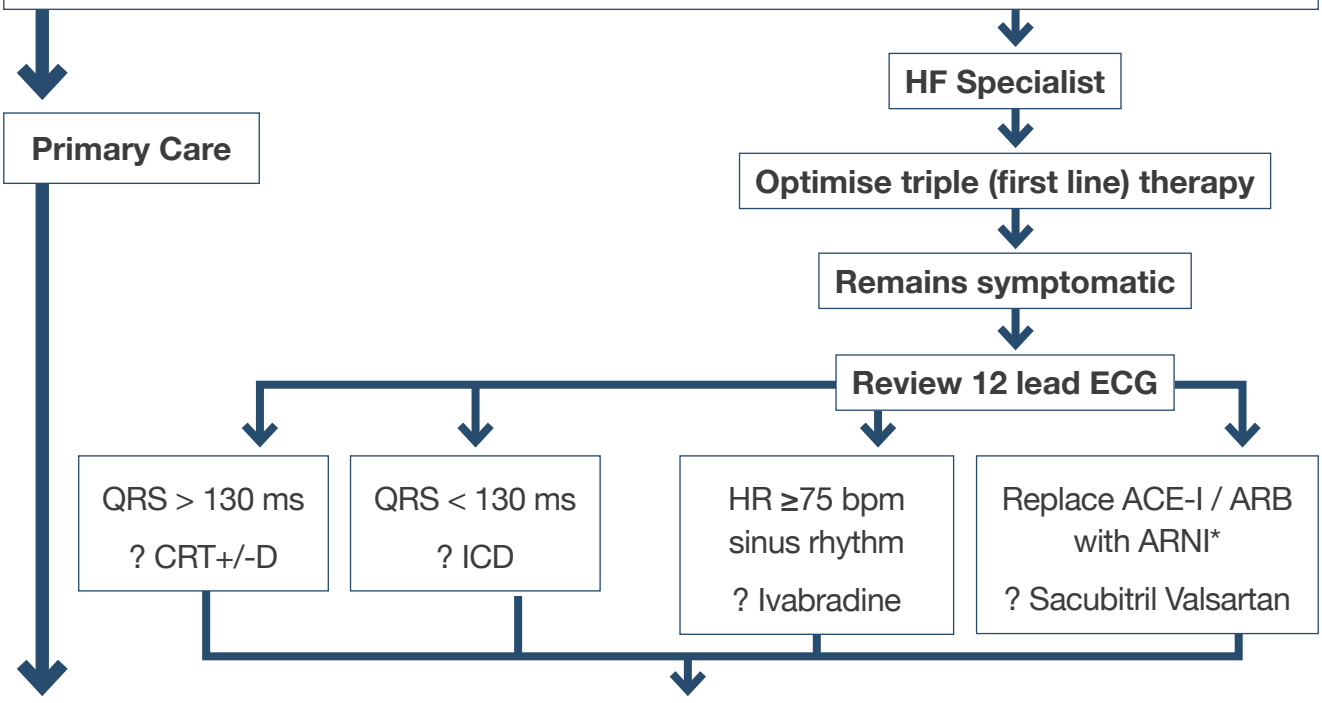
Expected treatment pathway for HFrEF with LVEF <40%

For patients with LVEF 40%-49% discuss with HF Specialist Team.

Diuretics if fluid retention (dynamic dosing – up or down)
Commence ACE-I* + beta-blocker
Consider MRA if symptomatic**
Titrate to maximum tolerated doses
Refer to HF nursing team for patient advice and titration.
Urgently if complex, unstable, or at risk of hospital admission.

*or ARB if intolerant of ACE-I **if GP initiates MRA ensure clinical assessment and monitoring of U&E's in 10 - 14 days.

If GP still managing patient reassess Heart Failure status & symptoms (ECG and suitability for CRT device) – if patient still symptomatic despite ACE/BB/MRA**, refer back to HF specialist nursing team or cardiology for advice as other specialist treatments may be indicated as outlined for information below in HF Specialist pathway.



Long term FU in primary care

Consider 6/12 review as per NICE guidance^
Adjust diuretics as per clinical status
^QOF recommends annual review of functional status and medication.

Continue FU in secondary care

Consider digoxin, hydralazine, nitrates

Involve palliative care as required

Expected Primary Care management of decompensated Chronic Heart Failure aiming to avoid hospital admission

Confirm previous diagnosis of HF and what type (HFrEF vs HFpEF) with echo report.

Management of decompensated heart failure. Check U&E's, FBC and ECG to try and identify cause of decompensation and manage accordingly.

Primary Care to adjust loop diuretic as appropriate, while referring to HF Specialist Nurse. Aiming for admission avoidance but the HF nurse has access to specialist care through HF MDT if required to escalate treatment in the community with a thiazide or admit / attend for IV diuretics.

Provide patient with information: Give patient advice sheet, advise patient to purchase weighing scales and **blood pressure monitor** to record daily weights, BP and Pulse.

Refer to HF Nurse Specialist:
If patient requires specialist HF assessment. Referral should include:

- Copy of latest Echo report confirming Heart Failure
- Recent medication changes
- Blood results.

Also GP to telephone HF Nurse to discuss referral if patient at risk of emergency hospital admission.

What types of support the HF Nurse will offer: see also CHFNS pathway Appendix 1

- Monitoring & Medicines management as per NICE guidance
- Complex diuretic management.
- Referral to appropriate agencies / MDT / services
- Liaise with Consultant-led MDT- Heart Failure for specialist advice
- Consideration for further interventions

To note – GP to check referral criteria for local Community HF nursing service if commissioned.

Heart failure review

(Suggested template for Primary Care)

Date:

Patient details:

1. Background

Type of HF:

Date of HF diagnosis:

Date of most recent echocardiogram (echo):

2. Symptoms

Are symptoms stable?

NYHA class =

Orthopnoea / PND

Peripheral oedema

New York Heart Association (NYHA)

- **Class I – NO** limitation on physical activity. Ordinary physical activity does not cause undue fatigue, palpitation and dyspnoea.
- **Class II – SLIGHT** limitation of physical activity. Comfortable at rest. Ordinary activity results in fatigue, palipation and dyspnoea.
- **Class III – MARKED** limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palipation and dyspnoea.
- **Class IV – UNABLE TO CARRY ON ANY PHYSICAL ACTIVITY WITHOUT DISCOMFORT.** Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

3. Medication

HFrEF?

ACEi/ARB maximum tolerated?

B-Blocker maximum tolerated?

MRA maximum HF dose?

Suitable for ARNI? (see appendix 2. If Yes refer to HF Team)

4. Devices

HFrEF

Devices and dates implanted:

ICD?* Yes or No

*check DNAR CPR status to consider when ICD needs deactivation.

CRT? Yes or No

If No to device perform ECG to check QRS duration:

Check patient knows date for next device follow up appointment?

5. Observations

Pulse rate:

Pulse: Regular: or Irregular:

***If not known AF and pulse irregular or unsure:** Use Lead 1 ECG device if available. If abnormal GP to review for diagnosis and treatment. Book in for next available 12 lead ECG.

Otherwise arrange immediate or next available appointment for 12 lead ECG and GP to review for diagnosis and treatment.

***If known AF** check patient is anticoagulated with correct dosing.

Atrial fibrillation (data required for CVDPrevent audit analysis)

- CHA2DS2-VASc
- HAS-BLED (Review modifiable risk factors)
- Prescribed anticoagulation
- If Warfarin patient check TTR and latest INR:

- Time in therapeutic range (TTR): - Last INR result:

- Review of anticoagulation

Blood pressure

Check sitting BP **and standing BP:**

*If significant postural drop in BP seek advice from GP.

High blood pressure (data required for CVDPrevent audit analysis)

- BP control to NICE guidance
- Home or ambulatory blood pressure monitoring
- eGFR readings
- CVD risk assessment and interventions

6. Bloods

FBC

U+E

*consider if other bloods need repeating? Eg:

LFT Lipids

TFT HbA1c

7. Behavourial change support

Smoking status:

Smoking interventions and stop smoking medications:

Height: Weight:

BMI recording: Waist circumference:

Alcohol consumption and interventions etc:

8. Contact with other services

Co-morbidities?

Cardiac rehabilitation?

Community Nursing Team?

Community Matrons?

Frailty Team?

Lives in care home?

Carer at home?

Main support service:

Others:

Appendices

Appendix 1: Community Heart Failure Service Pathway

(Example pathway)

HEART FAILURE DIAGNOSIS CONFIRMED

Refer to Community Heart Failure Service
Referral should include:

• Copy of latest Echo report confirming Heart Failure • Recent medication changes • Blood results.

Tel: ..... Email: .....

*GP to also telephone HF Nurse to discuss referral if patient at risk of emergency hospital admission.

Urgent referrals

Telephone contact within 1 working day and home or clinic review within 2-10 working days*

- Patients in an exacerbation of heart failure.
- Recent hospital admission / discharge with primary diagnosis of heart failure.
- In need of specific heart failure palliative care management if required

Non-urgent referrals

Telephone contact and clinical assessment review from a CHFNS within 4 weeks*

- Stable patients requiring titration of evidence-based medication as per NICE guidance for LVSD patients.
- Patients requiring education and guidance with self management strategies

Patients then become part of the active heart failure specialist nurse caseload

Unstable

Home review within 2 working days*

- Patient in exacerbation or high risk of exacerbation
- Recent hospital discharge

- Monitoring & Medicines management as per NICE guidance
- Complex diuretic management.
- Referral to appropriate agencies / MDT / services
- Liaise with Consultant-led MDT- Heart Failure for specialist advice
- Consideration for further interventions (CRT / Ultrafiltration)

Stable

- Optimised on evidenced based heart failure medication
- Personalised care plan in place
- No exacerbations of heart failure or medication changes within the past 3 months

HF Nurse will refer back to GP / practice nurse for on-going heart failure review as per NICE guidelines / QOF**

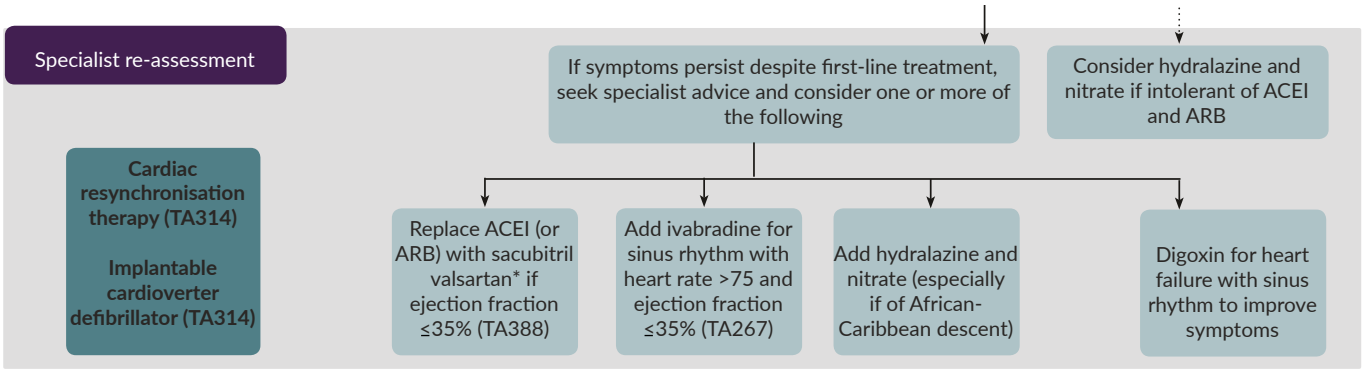
If patient decompensates with HF again refer back to HF nursing team as per this pathway.

Consider palliation if appropriate (see palliative care pathway)

*Normal working days are Monday – Friday 9am-5pm except bank holidays
**Gp to refer housebound patients to District Nursing team / Community Matrons if required for Integrated chronic disease review for heart failure management, heart failure review as per NICE guidelines / QOF.
Note – *GP to check referral criteria for local Community HF nursing service if commissioned.

Appendix 2: Specialist re-assessment and possible treatment options for HFrEF

NICE NG 106: management of Chronic Heart Failure in Adults (2018)



*Measure serum sodium, potassium and assess renal function before and after starting and after each dose increment.
If eGFR is 30 to 45 ml/min/1.73 m², consider lower doses or slower titration of ACEI or ARBs, MRAs, sacubitril valsartan and digoxin.

This is a summary of the recommendations on management from NICE's guideline on chronic heart failure. See the original guidance at www.nice.org.uk/guidance/NG106

ARNI:
Sacubitril/Valsartan (Entresto®)

Sacubitril/Valsartan contains the combination of sacubitril (a neprilysin inhibitor) and the angiotensin receptor blocker valsartan. It has been shown to improve life expectancy and reduce the likelihood of hospital admission in patients with HFrEF (ejection fraction ≤35%) who are still symptomatic despite treatment with an ACE inhibitor or angiotensin receptor blocker (ARB). It is approved by NICE (**NICE TA 388** – 2016) who recommend that **treatment with sacubitril valsartan should be started by a heart failure specialist with access to a multidisciplinary heart failure team.**

Sacubitril + valsartan may be considered **as an alternative** for patients on a stable dose of ACEi/ARB who are NYHA II-IV with an LVEF≤35%.

The starting dose is 24/26mg or 49/51mg twice a day which is then titrated to maximum tolerated dose (target dose 97/103mg).

- To reduce the risk of angioedema **any ACEi must be permanently discontinued and must be discontinued for at least 36 hours prior to initiation** of sacubitril +valsartan.
- Any ARB (other than the valsartan in Entresto®) must be permanently discontinued but a break in treatment is not needed.

Continue to monitor renal function, electrolytes (K+, Na+), and blood pressure and for signs of angioedema (as you would for standard ACEi/ARB therapy).

Ivabradine

Ivabradine is approved by NICE (**NICE TA 267** - 2012) and may be considered for patients with HFrEF, NYHA II-IV symptoms, in sinus rhythm with heart rate ≥75bpm despite the maximum tolerated dose of beta-blocker licensed for heart failure.

Note: up-titration of the beta-blocker to target dose should be considered first.

Target doses of beta-blocker are bisoprolol 10mg/day, carvedilol 25mg bd (or 50mg bd if weight over 85kg) or nebivolol 10mg/day.

The dose range for ivabradine is 2.5-7.5mg twice a day.

Digoxin

Digoxin is particularly useful for rate control in AF in heart failure patients and may be prescribed by the primary care team.

It can also be used, in low dose, as an adjunct for symptomatic relief for patients in sinus rhythm. Careful dosing is required in renal impairment.

Hydralazine + Nitrate

This combination is occasionally used for patients intolerant of ACEi and ARB or in addition to ACEi/ARB in symptomatic patients. Typically doses are: hydralazine 25mg twice /three times a day up to max 75mg three times a day + isosorbide dinitrate 10-30mg bd.

Implantation of a cardiac device

Some patients may meet the criteria for device therapy. Eligibility will depend on degree of LV impairment and ECG findings based on QRS duration. An informed discussion with a specialist is required before any patient is listed for a cardiac device.

This may be cardiac resynchronisation therapy (CRT-P) an implantable cardio-defibrillator (ICD) or cardiac resynchronisation therapy + implantable cardio-defibrillator (CRT-D).

Intravenous Iron Infusion

Many heart failure patients are not anaemic but have low iron stores and there is some evidence that repletion of iron can improve patient's symptoms/quality of life. Oral iron supplements are usually ineffective.

Criteria for intravenous iron is determined by the haemoglobin level along with assessment of ferritin and total iron saturation results.

This can be offered as a day case attendance according to local pathways.

Please note if a patient is anaemic do not refer to the heart failure team for IV iron - this should be investigated in line with clinical need.

This document is an aid and not a replacement to clinical judgement.

Top tips for Heart Failure Specialist Nurses when reviewing patients with Chronic Heart Failure in a virtual consultation

Use these top tips to assist your virtual consultation with adult patients who have been diagnosed with chronic heart failure with reduced ejection fraction. Following clinical triage, balance of risk may favour face-to-face review.

1 Is this patient suitable for review?

- Gain consent for VR and document clearly
- Manage expectations of the review e.g. length, what it will entail
- Do you have all the information required i.e. bloods, BP, HR, weight, etc.?
- Do they have a device that can be monitored remotely? e.g. implanted or telehealth device. If so, request readings ahead of review
- Do you need an interpreter? If so book three-way call
- Any recent contacts with a HCP? What information is available?

TOP TIPS

- If patient requires bloods or BP check, is it possible to obtain these prior to the virtual consultation?
- Is the patient using a phone, smartphone or computer? If not, could they borrow one (e.g. from family or carer)?
- Consider the use of video to enhance the consultation

2 Assessment checklist

- PND
- Orthopnoea
- Weight gain
- Oedema
- Bloating
- Palpitations
- Chest pain
- Episodes of syncope or presyncope?
- Appetite and fluid intake
- Exercise level on flat/incline
- Increased fatigue
- NYHA classification

TOP TIPS

- Ask questions regarding appropriate ADL e.g. have they taken the bins out?/ been gardening?/ walked the dog?
- Do they have any other co-morbidities that may affect these symptoms e.g. COPD?
- Ask patient if they feel that anything has changed?

3 Virtual examination – practical examples

- Can the patient move around or say a complete sentence without being breathless?
- Can you observe rate of breathing or signs of oedema?

TOP TIPS

- Ask patient to go and get something from another room to observe breathing
- Consider asking the patient or relative to test for pitting oedema
- Can the patient move the camera to show different parts of their body?

4 Medication review

- How well is the patient managing their drugs? Are they adherent?
- Has their medication been optimised? If not, can adjustments be made?

TOP TIPS

- Is there a family member or carer who can give an additional perspective?
- If accessible, check GP/pharmacist records to see if Rx have been collected

5 Next steps

- Following the patient assessment and examination use the information below to guide your next steps

No cause for concern

Set a next review date

- If there is no worsening of signs or symptoms
- If medication appears optimised, discharge to GP with management plan for primary care monitoring

TOP TIPS

- **Ensure patient has self-care advice, e.g. use of BP monitors, device wearables, home weighing scales, online support groups, remote downloadable education for device patients etc.**
- **Ensure patient has contact details for HF service should symptoms deteriorate**

Follow-up review required

Where appropriate:

- Assess need for F2F review and need for other services
- Advise medication changes if necessary and inform GP promptly
- Advise GP if other co-morbidities need to be considered
- Advise of repeat bloods and arrange
- Ensure timely FU appointment is arranged
- Patients for escalation to advanced/specialist therapies will need F2F FU following MDT discussion
- Ensure patient has self-care advice and contact details for HF service should symptoms deteriorate

Urgent care needed

- For significant or worsening clinical features of HF decompensation which is difficult to manage at home, consider discussing admission or urgent secondary care assessment with HF cardiologist or physician on call
- Dial 999 if severe signs and symptoms with acute haemodynamic compromise, e.g. severe breathlessness, chest pain, palpitations and syncope

ADL = activity of daily living, BP = blood pressure, COPD = Chronic obstructive pulmonary disease, CRT = cardiac resynchronisation therapy, F2F = face to face, FU = follow up, HF = Heart failure, HR = heart rate, MDT = multidisciplinary team, NYHA = New York Heart Association, PND = paroxysmal nocturnal dyspnoea, Rx = prescription, VR = virtual review

NYHA symptom grading
NYHA I - No symptoms
NYHA II - Mild symptoms (e.g. walking)
NYHA III - Marked limitation
NYHA IV - Severe limitation (e.g. at rest)

This infographic has been developed and funded by Novartis. It has been produced in collaboration with Ms Carys Barton and Dr Jim Moore. This infographic is endorsed by the Primary Care Cardiovascular Society (PCCS) and the British Society for Heart Failure (BSH).

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NOVARTIS

Primary Care Cardiovascular Society

Driving primary care to deliver the best in cardiovascular health

Top tips for reviewing patients with Chronic Heart Failure in a virtual consultation

Use these top tips to get the most out of your virtual consultations with your adult patients who have been diagnosed with chronic heart failure with reduced ejection fraction

1 Consultation preparation

- What is the reason for the consultation?
- Review the patient's clinical record
- Any recent cardiac decompensation, hospitalisation or contact with the HF services?
- Have they had any recent blood tests?
- Any recent relevant investigations?

2 Encourage the use of technology

- Is patient using a phone, smartphone or computer?
- Consider the use of video to enhance the consultation

TOP TIP

- If patient doesn't have a smartphone could they borrow one (e.g. from family member or carer)?

3 Assessment and presenting history

- Have they noticed a change in ADL, increased fatigue or change in exercise tolerance, e.g. NYHA? If exercise tolerance has changed is it gradual or sudden?
- Are they breathless while lying flat or wake in the night feeling breathless?
- Have they had newly developed or worsening of ankle swelling or increases in weight?
- Have they been aware of palpitations?

TOP TIPS

- Do they have a home BP monitor? If so, record BP and pulse
- Ask questions regarding appropriate ADL e.g. have they taken the bins out?/ been gardening?/walked the dog?
- Do they have scales? If so, record weight
- Do they have any other co-morbidities that may affect these symptoms e.g. COPD?

4 Virtual examination- practical examples

- Can the patient move around or say a complete sentence without being breathless?
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TOP TIPS

- Ask patient to go and get something from another room to observe breathing
- Consider asking the patient or relative to test for pitting oedema
- Can the patient move the camera to show different parts of their body?

5 Medication review

- How well is the patient managing their drugs? Are they compliant?
- Has their medication been optimised?

TOP TIPS

- Is there a family member or carer who can give an additional perspective?
- Consider the use of a dosette box

6 Next steps

- Following the patient assessment & examination use the information below to guide your next steps.

No cause for concern

Set a next review date

- If there is no worsening of symptoms or signs
- If medication appears optimised
- If patient is reassured

TOP TIP

Remind patient of how to identify early signs of their condition worsening and when they should be seeking advice

Seek further advice

Call or refer to HF specialist team or cardiologist

- If patient's symptoms or signs have worsened, e.g. minor change in NYHA class, consider increasing diuretic medication whilst seeking advice
- If concerns over adherence to medication
- Consider further tests whilst pending advice: U&E, eGFR, FBC & ECG etc.
- Consider reviewing patient again in 48-72 hours

Urgent action needed

Act immediately, e.g. seek emergency specialist advice, call 999

- If patient has chest pain and severe breathlessness
- If there is a significant change in NYHA class
- If patient has acute decompensation (hypoxia, hypotension and tachycardia)

HF= Heart failure, ADL = activity of daily living, BP = blood pressure, COPD = Chronic obstructive pulmonary disease, U&E = Urea & electrolytes, eGFR = estimated glomerular filtration rate, FBC = full blood count, ECG = electrocardiogram, NYHA = New York Heart Association

NYHA symptom grading
NYHA I - No symptoms
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This infographic has been developed and funded by Novartis. It has been produced in collaboration with Dr Majid Akram and Dr Jim Moore. This infographic is endorsed by the Primary Care Cardiovascular Society (PCCS).

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Primary Care Heart Failure Patient Advice Sheet

Follow up: you may be referred by your GP to be seen in the cardiology outpatient clinic or remain under your GP for ongoing management of heart failure. Some patients may also be referred to a heart failure specialist nurse. You will be told by your GP what follow up to expect.

Monitoring your blood pressure and pulse: you should purchase a home **blood pressure monitor** (HBPM), take regular readings and keep a record of your blood pressure, pulse rate and note if your pulse feels regular or irregular so you can share them with your doctor or nurse when you have a review.

Monitoring your weight: weigh yourself every morning. If your weight goes up you could be retaining fluid. Either tell your doctor or nurse or self-manage (if you have been advised to) if your weight goes up by 2 – 4 pounds (about 1 kilo) in 2 days as you may need a change to your treatment.

Worsening of symptoms: if you notice a worsening of your breathlessness, have more ankle swelling, or notice a sudden weight gain, if your doctor or nurse has advised you then self manage for 3 days or telephone your doctor or nurse as you may need a change to your treatment.

Self Management of diuretics for 3 days: if sudden weight increase and/or worsening symptoms if indicated your doctor or nurse may give you a self management advice sheet.

Activity: try to be as active as your condition allows. Walking is good and can be built into your daily regime. If you get breathless during exercise, you should slow down or stop.

Rest: if you have oedema (swelling) in your legs it will help when resting to elevate your legs on a footstool. If your breathing feels more difficult lying flat in bed try increasing the amount of pillows you use.

Diet: it is important to reduce the amount of salt in your diet as it can make you retain water. Do not add salt at the table and avoid cooking with it. Avoid salty foods such as Marmite, Bovril and crisps. Convenience foods are also particularly high in salt. In addition we recommend a 'healthy diet': reduce the amount of saturated fat, aim to eat at least five portions of fruit and vegetables a day, and eat fish twice a week.

Alcohol: drinking too much can sometimes make your heart failure worse so drink no more than 1 or 2 units of alcohol a day. Some patients will be advised to have none.

Medication: you will be started on a number of drugs that will improve your symptoms and are a key part of your treatment. It is important to continue taking the medication unless instructed differently by your doctor or nurse. If you have any problems taking your medicines or getting supplies please speak to your doctor, nurse or pharmacist.

Smoking: if you smoke, stop smoking. If you would like a referral to a smoking cessation service who can support you though this process please talk to your doctor or nurse.

Vaccines: make sure you have an annual flu vaccine and a one off vaccine for pneumonia.

Support: If you have any questions please ask your doctor or nurse. Further information can also be found in the **resource page** where the **British Heart Foundation Heart Failure hub** and the **Pumping Marvellous Foundation Heart Failure Toolkit** hold all their resources for patients and families.

Heart Failure Patient – 3 day Self-Management Advice

Look out for signs and symptoms of excess fluid. If your weight goes up suddenly overnight or over a couple of days by 2-4lbs or 1-2 kgs, you notice increased breathlessness, and / or increased swelling in the ankles / legs.

ACTION: take an extra water (diuretic) tablet for 3 days then reduce back to your usual prescribed dose.

So if you take Bumetanide take 1mg extra tablet for 3 days.

Or if you take Furosemide take 20mg or 40mg extra tablet for 3 days.

On day 4 when you have returned to your usual dose of Bumetanide or Furosemide, check how your symptoms are? Have they improved? Has your weight gone down? Leg swelling reduced? Breathlessness improved?

ACTION: If the answer is NO to these questions then please contact whoever supports you to manage your heart failure condition, this could be your GP or Specialist Heart Failure Team. You will need to discuss with them that your symptoms haven't improved and agree an ongoing plan. You will also need a blood test arranged if the extra diuretic continues for longer than the 3 days.

If you have a productive cough and are coughing up yellow or green sputum then it is likely you have a chest infection and you may need antibiotics.

ACTION: Please telephone your **GP for advice**. Or if you have **COPD** and are known to the Community Respiratory Team please ring them for advice or review.

Rest at night – If your breathing feels more difficult lying flat in bed try increasing the amount of pillows you use. Try 1 or 2 more pillows so your head and shoulders are more raised. Or if you have 4 – 5 pillows you can position them in the bed so they form an armchair and you can be in a sitting position to help you breathe easier.

Breathing exercise – if you feel short of breath, anxious or frightened try a simple breathing exercise on repeat and it will help you feel calm. You can practice this whenever you want: **Visualise smelling a flower** – breathe in through your nose. **Then blowing out a candle** – blow out through your mouth.

Fluids: it is important to find a balance – think of yourself as a spirit level! The diuretics are removing the excess fluid from your body but you also need to drink fluids so you don't feel really dry in the mouth. If you feel dizzy or light-headed when you go from sitting to standing up, try sitting down and drink a glass of water before standing up again.

Diet: it is important to reduce the amount of salt in your diet as it can make you retain water. Also avoid the use of LoSalt as this contains high levels of potassium.

Reduced appetite: If you have a poor appetite, try eating as much or as little of whatever you want. Try to have small frequent meals and snacks. If you are missing salt try adding pepper or herbs to give food more flavour.

Support: If you have any questions or are unsure about any of the self-management advice, please telephone your doctor or nurse for advice.

Resources for Clinicians and Patients

British Heart Foundation

For patients:

BHF **https://www.bhf.org.uk/informationsupport/support/managing-your-heart-failure**

British Heart Foundation: Living with heart failure booklet **https://www.bhf.org.uk/publications/heart-conditions/living-with-heart-failure**

Heart Failure Matters patient information **www.heartfailurematters.org**

Plus BHF helpline info:

Call* **0300 330 3311** open weekdays 9am - 5pm, Saturdays 10am - 4pm. Or email at **hearthelpline@bhf.org.uk** and BHF nurse will get back to you as soon as possible. **costs are the same as calling a home or business landline.*

For healthcare professionals:

https://www.bhf.org.uk/for-professionals (Not HF specific)

Pumping Marvellous Foundation

For patients:

Resources for people living with heart failure **https://pumpingmarvellous.org/heart-failure-toolkit/**

Pumping Marvellous Support Community **https://www.facebook.com/groups/helpforhearts**

Contact **01772 796542** or email **hearts@pumpingmarvellous.org**

For healthcare professionals:

NHS Teams patient information order form **https://pumpingmarvellous.org/nhs-order-form/**

Cardiomyopathy UK

http://www.cardiomyopathy.org

NICE Guidelines

NICE Acute Heart Failure Guideline – 2014 (CG187) **https://www.nice.org.uk/guidance/cg187**

NICE Chronic Heart Failure Guideline – 2018 (ng106) **https://www.nice.org.uk/guidance/ng106**

CVD Guidance For Primary Care

CVD prevention during the COVID-19 pandemic – A guide for primary care

Connecting with music

For patients:

m4d Radio. A group of 5 themed radio stations available 24 hours a day, 365 days a year playing music that evokes memories.

Choose your era, listen and enjoy… **https://m4dradio.com/**