

Heart failure: Literature Review

Christine Nlandu

Lakeview College of Nursing

Dr. Ariel Wright

06/04/2021

Heart failure

According to Hinkle and Cheever (2018), more than 85.6 million Americans have one or more types of cardiovascular diseases. Cardiovascular is one of the leading causes of death for men and women in the United States. Cardiovascular disease affects people from diverse racial and ethnic backgrounds. Additionally, one of the most severe complications of heart disease is heart failure. Heart failure is a clinical disorder that occurs when the structural or function of cardiac disorders compromise the heart's ability to receive or pump blood. In other words, heart failure is a chronic, progressive condition that results from certain diseases, including hypertension, coronary artery disease, valvular disorders, cardiomyopathy, and renal impairment associated with fluid overload. Heart failure monitoring is essential to nursing because it is a preventable disease. Nurses working with clients in any setting, including home, office, long-term care, hospital, or rehabilitation, must assess the cardiovascular system, identify specific prevention, and treatment strategies. A literature review's purpose on heart failure is to decrease the progression of the disease, which decreases hospitalization and risk of death.

Implementing a nurse discharge navigator reducing 30-day readmissions for heart failure and sepsis populations.

This article focuses on preventing unplanned readmissions of clients with heart failure 30 days following discharge. Data obtained from the case management, and they questioned clients 24 to 48 hours following discharge. In this study, 28 participants were 55 years old or older and English speakers. Twenty-four participants were diagnosed with heart failure; 6 of them came back to the hospital within 30 days after discharge (Weeks et al., 2020). A quarter of all clients admitted with heart failure went back to the hospital within 30 days. Therefore, nurses need to

focus on the prevention of unexpected rehospitalization 30 days following discharge. The importance of this article is to evaluate the influence of nursing discharge guidelines on the reduction of 30 days for heart failure clients.

Key Points

Hospital readmissions are costly and impact clients' outcomes. The author stated that one in five Medicare clients had 30-day unplanned readmission, which cost \$20 billion in Medicare alone (Weeks et al., 2020). To penalize hospitals that have high-rate readmissions within 30 days, Medicare reduces their payment. The authors also reported that clients who have heart failure are at high risk for unexpected 30 days readmissions and nursing discharge navigator plans were to reduce 30 days rehospitalization following discharge (Weeks et al., 2020). However, Medicare does not pay hospitals that have many rehospitalization cases because readmission is expensive. Creating a complete discharge plan will reduce readmission, which impacts clients' outcomes and costs.

Assumptions

Reducing 30 days of readmission when implementing a nursing effort is possible. In 2018 readmission within 30 days of Medicare clients at the age 65 and older was 14.9 % in the United States (Weeks et al., 2020). During this study, the percentages of heart failure readmission were higher than those in 2018. It means that it is possible to improve the care of heart failure to avoid rehospitalization. When reducing rehospitalization, it is necessary to consider communication, sufficient instruction to clients, their families, and certainty about prescription. In addition, enhance the transition of care is possible by improving medication education, organizing follow-

up, and establishing a complete discharge plan, which reduces readmission within 30 days (Weeks et al., 2020).

Deficit/Conclusion

Establishing a completed discharge plan, follow-up, and education will help hospitals reduce readmission and cost. In order to obtain a better outcome, it is necessary to administer appropriate treatment. It is essential for nursing to release clients only when they are stable and can care for themselves at home. Giving relevant information to clients and their families about their nutrition, medication and respecting follow-up appointments before discharge increases patient outcomes. If nursing fails to accept the implications, it will increase rehospitalization, which increases Medicare costs, and affects clients' outcomes. Also, Medicare penalizes hospitals with a high rate of unexpected readmission (Weeks et al., 2020).

References

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer.

Weeks, K., Kile, D., & Garber, J. (2020). Implementing a nurse discharge navigator: Reducing 30-day readmissions for heart failure and sepsis populations. *Professional Case Management*, 25, 343-349. <https://doi.org/10.1097/NCM.0000000000000437>