Heart Failure Readmissions: From the Eyes of a Patient

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Problem Statement

- Management of heart failure can be very complex and is often unique to each patient; however, there are general guidelines that should be followed.
- Prevention of acute exacerbations can slow the progression of heart failure as well as increases the safety and overall wellbeing of the patient.
- When a patient who has acute congestive heart failure is readmitted, the cost and burden to the patient as well as the facility increase.

Research Purpose

- To explore, among a sample of patients who have acute congestive heart failure and have experienced an hospital readmission, their perceptions regarding factors that influenced their readmissions to the acute care setting.
- To identify the patient perception of areas of patient education that may influence readmissions rates.

Methodology/Design

- Qualitative phenomenology research with semi-structured interviews of patients readmitted to an acute care facility.

Sample

- Nonrandom, purposeful convenience sample (n=7)
- Eligibility Criteria

  Patient readmitted with acute heart failure, within 30 days of an initial admission to the research setting.

Findings

Category	A Deficit in Continuity of Care	Resilience in the Face of a Chronic Debilitating Illness	Heart Failure Knowledge and the Role of Education on Self-Care
Theme	Fragmented visits and Lack of communication	Spirit of Survivorship and Determination	Knowledge of heart failure home management and Poor response or poor follow through
Codes	"We couldn't get this doctor to understand that he wasn't breathing well…he said I don't think you need oxygen." "I would just as soon take a little pain. I have to get really bad before I'll come in for anything." "That doctor wants to know if I quit smoking. I told this doctor five years ago I quit smoking. You know, I mean, don't you know who I am?"	"Hospice. When I heard that I thought, you're bringing hospice into my room, into my house…forget it… I can walk and I can function and be damned if I'm going to lay here and wait to die." "I've had an objection from my home nurse because I like to go out and have lunch once in awhile. The nurse thinks I should stay in the house constantly. Well, I'm not bedridden, you know. I'm not homebound. I mean I should be. I like to see there's a world out there besides my little jail, I call it…but after about four or five days I start to cry, I get ready to cuss, I got to get out of the house." "My health is a little bit scary to me and I want it taken care of the best we can do, you know? I don't know of anything else I can be doing. But if there was a way to do it, I would do it. "	"That congestive heart failure diastolic dysfunction means that the heart doesn't open enough to let enough blood in" I'll exercise…then I regret it because then I go into all the problems here…I don't go hardly any further…it's kind of a little circle there…and that's where I live – that little circle" And I take that to doctor every time I have an appointment, you know. 'Your weights?' Yeah. I write it on a card every day and then I call it in every Monday and when I go see the doctor then I take that card with me.

Human Protections

- IRB approval was obtained from University of Mary and the host organization.

Instrumentation/Data Analysis

- A semi-structured interview of open ended questions was used to probe patients about their perceptions.
- Qualitative data were coded, categorized, sorted into themes and a final assertion made.

Final Assertion

- All patients who were interviewed displayed strength in character and perseverance for life despite facing multiple challenges of living with heart failure. Most could verbalize proper self care management measures they received as part of their heart failure education. Readmissions were experienced by all patients as a result of lack of adherence to their heart failure self care regimen, poor responsiveness of their bodies to heart failure management measures, and/or poor healthcare provider continuity.

Implications for Nursing

- Home Health Referral changes
- Palliative Care Consult to initiate advanced care planning
- Clear description of Hospice
- Communication in transition of care to utilize electronic medical record
- Heart Failure Action Plan