Empowering Nurses Healthier Hearts: Nurse –Led Interventions Reduce Heart Failure Readmissions

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Background

- Heart Failure (HF) is a chronic condition with rising prevalence and hospital readmissions are expected to increase by 2030 (Chestnut et al., 2021).
- HF management costs are projected to rise from $30.7 billion to 69.8 billion by 2030 (Dong et al., 2020)
- Advocate Sherman Hospital was above the 18.1% HF readmission target in 8 of 12 months in 2024.
- Despite following American Heart Association (AHA), American College of Cardiology, Heart Failure Society of America guidelines, nursing led patient education fell below standards, likely contributing to higher 30- day readmissions.

Clinical Question

- PICOT Question: In adult hospitalized patients with acute decompensated heart failure, how do evidence-based best practices compared with current practice affect all-cause heart failure readmissions within 30 days?

Search Strategy / Approach

- Databases used: CINAHL, MEDLINE, PUBMED
- Keywords: Heart Failure (HF) Readmissions, American Heart Association reduce heart failure readmissions, Nurse Led interventions for HF patients, HF self-management, HF self-maintenance, Teach-back patient education, Self Check Tool, Patient education 60 minutes, 48-72 hour follow up phone calls, HEART program, discharge readiness, 7- day Follow up appointments

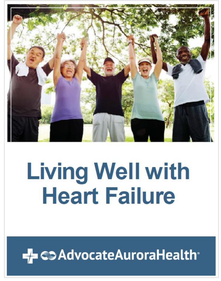




Figure 1. Heart Failure Patient Education

Synthesis of Evidence

- Nurse-led transitional care with teach-back education improves self-care and reduces readmissions (Chestnut et al., 2021; Oh et al., 2023).
- A 15-minute private discharge education session by a trained assistant boosts patient confidence and self-care (Oh et al., 2023).
- The B-PREPARED score helps address key discharge needs like medication and support (Dong et al., 2020).
- The HEART bundle reduces HF readmissions through coordinated care and follow-up (Dong et al., 2020).

Practice Change

- Project Design: Strategies were developed and implemented to reduce 30-day readmissions for Acute Decompensated Heart Failure (ADHF) patients.
- Subjects: The target population included ADHF patients, both English and Spanish speaking.
- Setting: Advocate Sherman Hospital Cardiac Care Unit, a 48-bed unit.

Implementation Plan

- Nursing Education:
  - Reviewed AHA's Heart Failure "Get With The Guidelines" to improve knowledge of care protocols.
  - Reviewed fluid volume excess care plan and identified key documentation for patient education.



HEART
H: Heart doctor visits patient in hospital
E: Education about Heart Failure
A: After Visit Summary with 7- day appt.
R: Reach out to patient in 48-72 hours
T: Treat patient in clinic by 7- day visit
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Figure 2. Poster explaining nurse led interventions and example of HEART program reminders

Cont. Practice Change

- Procedure and Tools:
  - Administered the B-Prepared Checklist at both admission and prior to discharge.
  - Delivered 60 minutes of individualized patient education during the hospital stay.
  - Conducted follow-up phone calls 48 to 72 hours after discharge.
  - Distributed the Live Well HF booklet as part of the HEART initiative.
  - Monitored attendance at 7-day post-discharge follow-up appointments.

B-PREPARED Discharge Readiness Scale

Admission

Item #		Score
1	I understand what my diagnosis is.	
2	I know what symptoms to watch for that may indicate a problem.	
3	I understand how to take my medications properly.	
4	I know what activities, diet, or lifestyle changes are recommended for my condition.	
5	I feel confident managing my health at home.	
6	I know what equipment or medical supplies I will need and how to use them.	
7	I have arranged the services I need (e.g., home health, transportation).	
8	I know when and where my follow-up appointments are.	
9	I know how to contact my health care team if I have questions or concerns.	
10	I have received written instructions so I can understand.	
11	I have someone to help me if I need support at home.	
	Total Score (Max) 22	

B-PREPARED Discharge Readiness Scale (Dong et al., 2020)

Instructions: Rate each item based on how well-prepared the patient feels.

Scoring: 0 = Not at all, 1 = Somewhat, 2 = Completely



Use this checklist to help organize and streamline the follow-up phone call to ensure that it is comprehensive yet focused.

Early Post-Discharge: **Checklist for 48-72 Hour Follow-Up Phone Call**



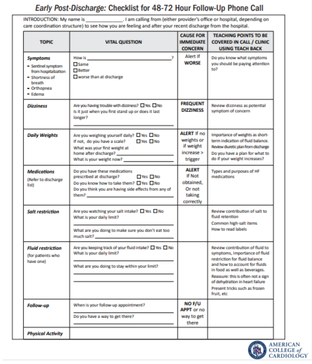


Figure 3. BEPREPARED Discharge Readiness Scale and Discharge Phone call Checklist

Results

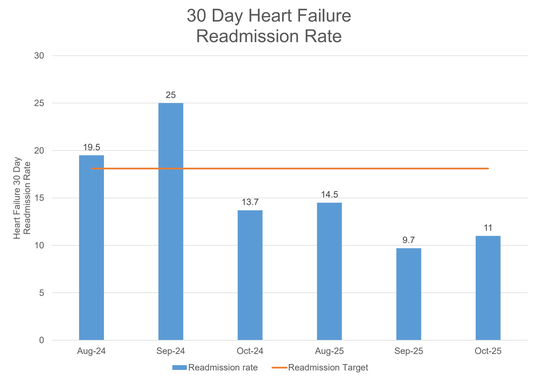


Figure 4. Heart Failure Readmissions Rates

Conclusions

- Between August and October 2024, the average readmission rate was 19.4%, exceeding the target of 18.1%.
- Following the implementation of initiative, the average readmission rate for the same period in 2025 declined to 11.78%
- Cardiac Care Nursing staff increased participation in HF education and documentation.
- Enhanced education for both patients and caregivers played a vital role in minimizing heart failure exacerbations.
- Challenge: Coordinating and completing follow-up calls within 48–72 hours required substantial time investment.
- Findings are consistent with Chestnut et al. (2021) and Oh et al. (2023), demonstrating that nurse-led teach-back education enhances self-care abilities and lowers readmission rates.
- Outcomes also align with Dong et al. (2020), confirming that the B-PREPARED score effectively identifies and addresses critical discharge needs.

Implications for Practice

- Individualized education interventions have the potential to substantially reduce the risk of patient readmission.

Recommendations:

- Implement structured nursing education programs focused on heart failure.
- Provide comprehensive heart failure patient education, ensure discharge readiness utilizing B=PREPARED and HEART frameworks, and conduct follow-up phone calls within 48-72 hours post-discharge to support reduced readmissions.

Limitations:

- It was not possible to reach all patients within 48–72 hours following discharge.
- Additional challenges were encountered when attempting follow-up with patients residing in Skilled Nursing Facilities.

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