MULTI-DISCIPLINARY TEAM WORKING IN END OF LIFE CARE OF ADVANCED HEART FAILURE

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HEART FAILURE

PROGNOSIS: Mortality is 30% in the first year following diagnosis after a hospital admission, then 10% per year.

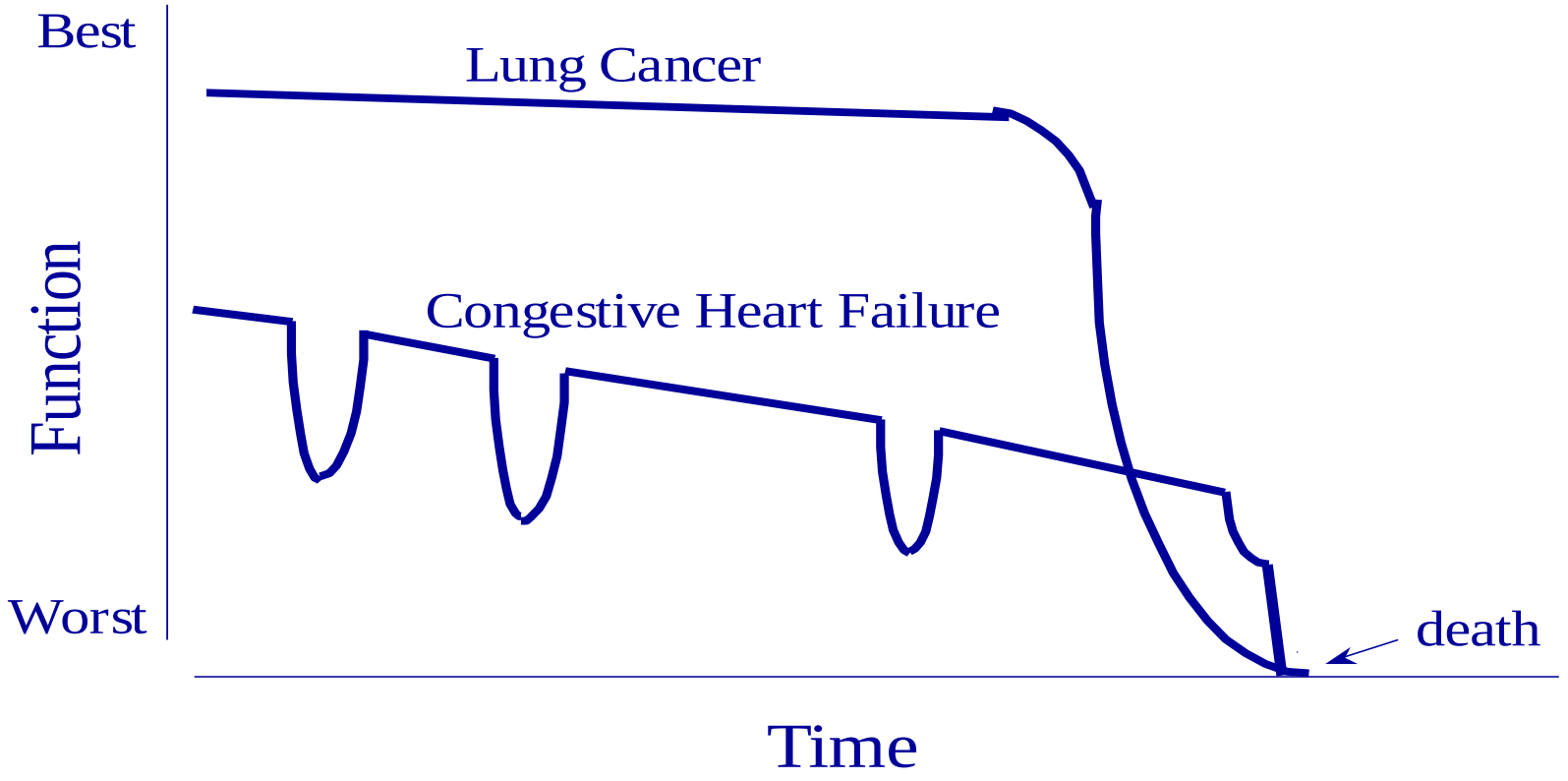
The prognosis of heart failure remains poor, and is worse than for breast or prostate cancer.

Advanced Heart Failure

There is a reluctance by primary and secondary care physicians to refer patients with heart failure to palliative care services due to unpredictable prognosis (Hanratty et al 2002 BMJ).

This uncertainty can virtually paralyse doctors, potentially preventing them from telling patients when they have reached the terminal phase of their illness, and from planning appropriate care.

Trajectory of Dying for Lung Cancer or CHF



Patients with advanced heart failure experience:

- Gradual decline punctuated by periods of acute deterioration.
- Little understanding of diagnosis and prognosis
- Relatives isolated and exhausted.
- Daily grind of hopelessness
- Much co-morbidity to cope with
- Shrinking social world dominates life, little contact with health and social services.
- Less access to benefits with uncertain prognosis.
- Less priority as a “chronic disease” and less priority later as uncertain if yet “terminally ill”.

NICE 2018:

Do not use prognostic risk tools to determine whether to refer a person with heart failure to palliative care services.

Indication of poor prognosis:

- Advanced age
- Refractory symptoms
- 3 or more hospital admissions, or episodes of decompensation in the last year
- Dependent in 3 or more ADLs
- Cachexia
- Hyponatraemia
- Low serum albumin
- Multiple device activity (if has ICD)
- Multiple co-morbidities

End of Life Care (NICE 2018)

- Do not offer long-term home oxygen therapy for advanced heart failure. Be aware that long-term home oxygen therapy may be offered for comorbidities such as chronic obstructive pulmonary disease and hypoxia. See NICE guidance on Chronic obstructive pulmonary disease in over 16s (CG101) .

- If the symptoms of a person with heart failure are worsening despite optimal specialist treatment, discuss their palliative care needs with the specialist heart failure multidisciplinary team and consider a needs assessment for palliative care

Community MDT:

- Weekly nursing meeting to discuss symptomatic patients attended by palliative care nurse.
- Discuss palliative care referral with patient and family.

If patient/family in agreement:

- Formal referral to Palliative Care Service
- If patient is under care of a cardiologist, inform of condition and palliative care referral.
- Inform GP of referral and ask for GSF entry, DS1500, DNAR form to be completed at home visit (as appropriate).
- If ICD deactivation required, discuss with patient/family and make arrangements.
- HF nurse joint visit with Palliative Care Nurse.
- Continue with joint working.