Development of an Integrated Model of Palliative Care for Advanced Heart Failure Patients.

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Aim

To develop an integrated approach to care of patients with advanced heart failure in Brent to ensure better identification, palliation of needs and choices at the end of life.

Objectives

- *To identify end of life HF patients.*
- *Initiate an advanced HF forum to ensure all patients were discussed resulting in better medical management or EoL care formally agreed.*
- *Holistic assessment and appropriate referral to specialist palliative care.*
- *Anticipatory care planning.*

The Process

- *Literature review of services delivering palliative care to HF patients.*
- *Baseline audit.*
- *Steering group – all community stakeholders.*
- *Support of the NHS improvement programme and the NW London Stroke and Cardiac Network.*

Early Identification

- *Trigger tool developed to identify patients that may be entering their end of life phase.*
- *Guidance taken from Gold Standards Framework 'prognostic indicators', and 'Supportive Care in Heart Failure' 2008 Beattie and Goodlin.*
- *Patient then taken for discussion at the advanced heart failure forum.*

Trigger tool to identify patients that are a '*Cause for Concern*'

THE AIM OF THE TRIGGER TOOL IS TO HELP THE CLINICIAN IDENTIFY THOSE PATIENTS WHO MAY BE ENTERING THE FINAL STAGES OF HEART FAILURE. IF THE PATIENT MEETS TWO OR MORE OF THE FOLLOWING CRITERIA THE CLINICIAN SHOULD CONSIDER DISCUSSING THE PATIENT AT THE MULTI-DISCIPLINARY TEAM MEETING FOR CONFIRMATION.

Specific chronic heart failure triggers

- THE PATIENT WITH ADVANCED DISEASE MAKES A CHOICE FOR COMFORT CARE ONLY, NOT CURATIVE TREATMENT.
- THREE ADMISSIONS WITHIN THE PAST YEAR WITH SYMPTOMS OF HEART FAILURE.
- NEW YORK HEART ASSOCIATIONCLASS III OR IV, SHORT OF BREATH AT REST OR ON MINIMAL EXERTION DESPITE MAXIMAL MEDICAL THERAPY.
- DIFFICULT PHYSICAL OR PSYCHOLOGICAL SYMPTOMS DESPITE MAXIMAL MEDICAL THERAPY.

General predictors of end of life

- WEIGHT LOSS- GREATER THAN 10% OVER PAST SIX MONTHS.
- GENERAL PHYSICAL DECLINE.
- SERUM ALBUMIN <25G/L.

Renal Disease

- CHRONIC KIDNEY DISEASE (eGFR <15ml/min)
- PATIENTS WITH STAGE 4 OR 5 KIDNEY DISEASE WHOSE CONDITION IS DETERIORATING
- PATIENTS WHO HAVE DECLINED OR DISCONTINUED DIALYSIS.

The Forum

A patient identified as a ‘cause for concern’ is discussed at the advanced heart failure forum.

- *MDT format.*
- *Future management agreed, i.e medication review, BVVP, ICD or EoLC.*
- *Letter informing GP of management plan.*
- *HFN leads on patient management.*

Community Heart Failure Management

- Holistic assessment
- Use of EoL aide memoire to ensure palliative approach
- Preferred place of care document
- Referral to specialist palliative care when indicated by Patient and Carer Assessment tool (PACA)

Emergency folder

A red folder is kept in the home which contains essential management documentation.

- DNR paperwork
- Out of hours contact numbers
- London ambulance palliative handover
- Harmoni/UCC form
- Preferred place of care
- Anticipatory drug administration chart

References

- www.goldstandardsframework.nhs.uk
- Beattie, J., & Goodlin, S (2008) *Supportive Care in Heart Failure*. Oxford University Press, Oxford.

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