



Pall – Heart Failure

Palliative Care Assessment Tool



BC'S HEART FAILURE NETWORK
Quality care for quality life.



Identify who would benefit from a palliative care assessment

1) ASK yourself

- Would I be surprised if this patient died in the next 6-12 months? **YES** or **NO**

2) LOOK for one or more general clinical indicators

- Performance status poor (limited self care; in bed or chair over 50% of the day) or deteriorating
- Multiple hospitalizations in the past 6 months
- Patient needs more care at home or is in a residential care facility.
- Patient has multiple co-morbidities causing symptoms/functional decline

3) LOOK closer for two or more disease related indicators

- NYHA class III / IV heart failure due to valve disease, or coronary artery disease not amenable to surgery/angioplasty
- Persistent symptoms (breathlessness or chest pain) despite optimal tolerated therapy
- Renal impairment (eGFR <30 ml/min)
- Cardiac cachexia: progressive loss of lean body mass, reduced muscle strength, anorexia, fatigue and abnormal biochemistry (see below)
- Markers of chronic inflammation/cachexia –
Anemia: hemoglobin \leq 115, Uric acid \geq 565, albumen < 32
- Two or more acute episodes needing intravenous (furosemide and /or inotropes) therapy in last 6 months

If WOULD NOT be surprised AND patient meets criteria from LOOK categories – patient benefits from palliative care assessment



Integrate palliative care into patient assessment

- **Symptoms of advanced heart failure:** dyspnea, pain, fatigue, constipation, anorexia, nausea, dry mouth, delirium, dizziness, itch, anxiety, depression, insomnia,
- Function and quality of life?
- Level of patient and caregiver distress?
- **Information needs:** *“Tell me what you understand about your illness?”; “Are you the type of person who likes all the information and details about your condition including details about what will happen in the future?”*
- **Decision making:** *“Do you prefer to make healthcare decisions on your own or are there family or friends who you wish to be involved?”*
- **Patient-centered goals of care:** *“As your illness gets worse, what is most important to you?”; “What do you fear most about the future?”; “Is there anything that would be worse than death for you?”; “Does the treatment you are receiving feel right to you?”*
- **Ask re advance care planning** *“If you become too sick to speak for yourself who would make decisions for you?”; “Have you discussed your thoughts about the future with your family or ever put them down in writing?”*
- **Aware of all options?** *“There may come a time when we suggest treatments you don't feel comfortable with or a time when you want to stop a treatment. We will understand and support you in this decision and will continue to make sure you live as well as possible.”*



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Providence
HEALTH CARE



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Integrate palliative care into practice

- **Communicate/prepare:** *"We cannot cure you of heart failure but our goal is to help you live as well as you can for as long as you can. Although surgery/angioplasty is not appropriate for you there is always something we can do to help you. . ."*
- **Advance care planning:** *"We are not very good at predicting how long people live with heart failure so we will hope for the best but always have a plan for the worst."; "Can we take some time to discuss a plan for that time?"*
- **CPR Discussion:** *"We will do everything we can to help you live as well as you can for as long as you can, but when you die we will not try to bring you back."*
ICD: discuss when defibrillator deactivation should occur.
- **Control dyspnea and pain:**
 - Opioids are drugs of choice for dyspnea and pain refractory to cardiac meds.
 - Opioids are safe in cardiopulmonary disease but – start low, go slow.
 - Opioids with few/no active metabolites preferred in renal failure/frailty –no Tylenol #3 or morphine.
 - Regular symptoms = regular dosing with breakthrough
 - Always order a breakthrough dose (10% of total daily dose q1hr)
 - Increase the regular dose if >3 breakthroughs/day
 - Right dose = best control of symptom, fewest side effects
 - Always order a laxative with regular opioids
 - If side effects intolerable switch opioid
- **Symptom control = quality of life:** especially dyspnea/anxiety/depression/

Involve other healthcare providers or services

- **Community services essential:** family physician, home care nursing
- **Community resources:** spiritual and religious communities, bereavement support services
- **Patient and family education re palliative care:** Canadian Virtual Hospice www.virtualhospice.ca and local health authority resources
- **Involve Palliative Care team:**
 - Difficult to control physical or psychological symptoms
 - Disagreements or uncertainty among patient/family/staff regarding goals of care
 - Family distress despite explanation

References:

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