Integrated palliative care in the management of advanced heart failure

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Introduction

Heart failure (HF) remains a progressive and highly symptomatic disease that places great demands on patients, caregivers, and healthcare systems. Heart failure affects about 900,000 people in the UK with 60,000 new cases yearly and accounts for about 2% of the total NHS budget.[1,2] Studies have shown that an integrated-palliative care approach to managing heart failure will reduce hospital admissions, provide a better experience for patients and carers, support people when their condition becomes more advanced and enable them to have more choice regarding their end-of-life care.[3–5] However, despite growing numbers of guidelines from major cardiology societies including the European Society of Cardiology (ESC) and British Heart Foundation (BHF), the implementation of integrated palliative-heart failure management remains suboptimal.[6] The aim of this study is to assess the implementation of integrated palliative care in the management of advanced heart failure patients in a major tertiary cardiology centre in the UK.

Materials and methods

The electronic medical records of all 480 heart failure patients admitted to Leeds Teaching Hospitals Trust within the 6-month period of December 2020 to May 2021 were reviewed. Of this number, 228 patients with advanced heart failure with New York Heart Association (NYHA) stage III and IV with high symptomatic and psychosocial burden were recruited into the study. Data were gathered from electronic medical records using Microsoft Excel and analysed with IBM SPSS Statistics version 27.

Results and discussion

Among the 480 heart failure admissions during the study period, 228 patients with advanced heart failure and high symptomatic and psychosocial burden were recruited into the study. There were 125 men and 103 women with a mean age of 7.7±13.7 years; of these, 66.7% of patients had NYHA stage III symptoms and 33.3% had NYHA stage IV symptoms. 53.9% of the patients had HF with reduced ejection fraction (HFrEF), 40.3% had HF with preserved ejection fraction (HFpEF) and 15.7% had mid-range ejection fraction (HFmrEF).

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Table 1. Palliative care needs of advanced HF patients

Palliative care needs	Percent %
Dyspnoea	53.9
Oedema	53.1
Pain	28.1
Psychological needs	16.2
Social and spiritual needs	43.9

Many of the patients had significant physical and palliative care needs such as pain, dyspnoea, oedema, and psychosocial needs with approximately one-third having more than five hospital admissions in the past 2 years. Table 1 outlines the palliative care needs of participants.

Despite these significant needs, only one-third (69) of the patients had been referred to the palliative care team with only about one-quarter (58) of patients having integrated care plans in place. Furthermore, a third of the patients had no advance care plan in place or do-not-attempt-cardiopulmonary-resuscitation (DNACPR) decision, and a similar proportion had no escalation/level of care decisions documented. Also, 20.1% of patients had a cardiac device in situ, of which 5.1% were implantable cardiac defibrillators (ICDs); however, only 2.2% of patients with ICDs had an end-of-life device plan in place. In addition, despite nearly 29% of patients having a documented preferred place of end-of-life care, this was only achieved in 12.7% of cases.

Conclusion

Patients with advanced heart failure have significant physical and palliative care needs which remain largely unmet as evidenced in this study. We recommend an integrated heart failure-palliative care MDT be introduced trust-wide with referral triggers to include NHYA stage III and IV symptoms despite optimal therapy and complex physical and psychosocial needs. Finally, we recommend that heart failure palliative care be the subject of regular quality improvement strategies. ■

References

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