

# WORKING COLLABORATIVELY TO MEET THE PALLIATIVE CARE NEEDS OF PATIENTS WITH END-STAGE HEART FAILURE

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on behalf of the Wigan Specialist Palliative Care and Heart Failure services

## Introduction

- Heart Failure is a common problem in the UK with about 63,000 new cases per year.
- It carries a poor prognosis despite significant recent advances
- Survival rates are as bad as colon cancer, and worse than carcinomas of breast, uterus, cervix, bladder & prostate
- 40% of patients with Heart Failure die within a year
- The majority die within 5 years of diagnosis

## NICE Guidance for Management of Chronic Heart Failure (2003)

- There is substantial evidence that patients with heart failure and their carers have unmet palliative care needs
- The main areas of need include
  - Symptom control
  - Psychological and social support
  - Planning for the future
  - End of life care

## Recommendations

- Issues of sudden death & living with uncertainty are pertinent to all patients with heart failure. The opportunity to discuss these issues should be available at all stages of care.
- The palliative care needs of patients & carers should be identified, assessed & managed at the earliest opportunity
- Patients with heart failure & their carers should have access to professionals with palliative care skills **within the heart failure team**

## Developing services in Wigan

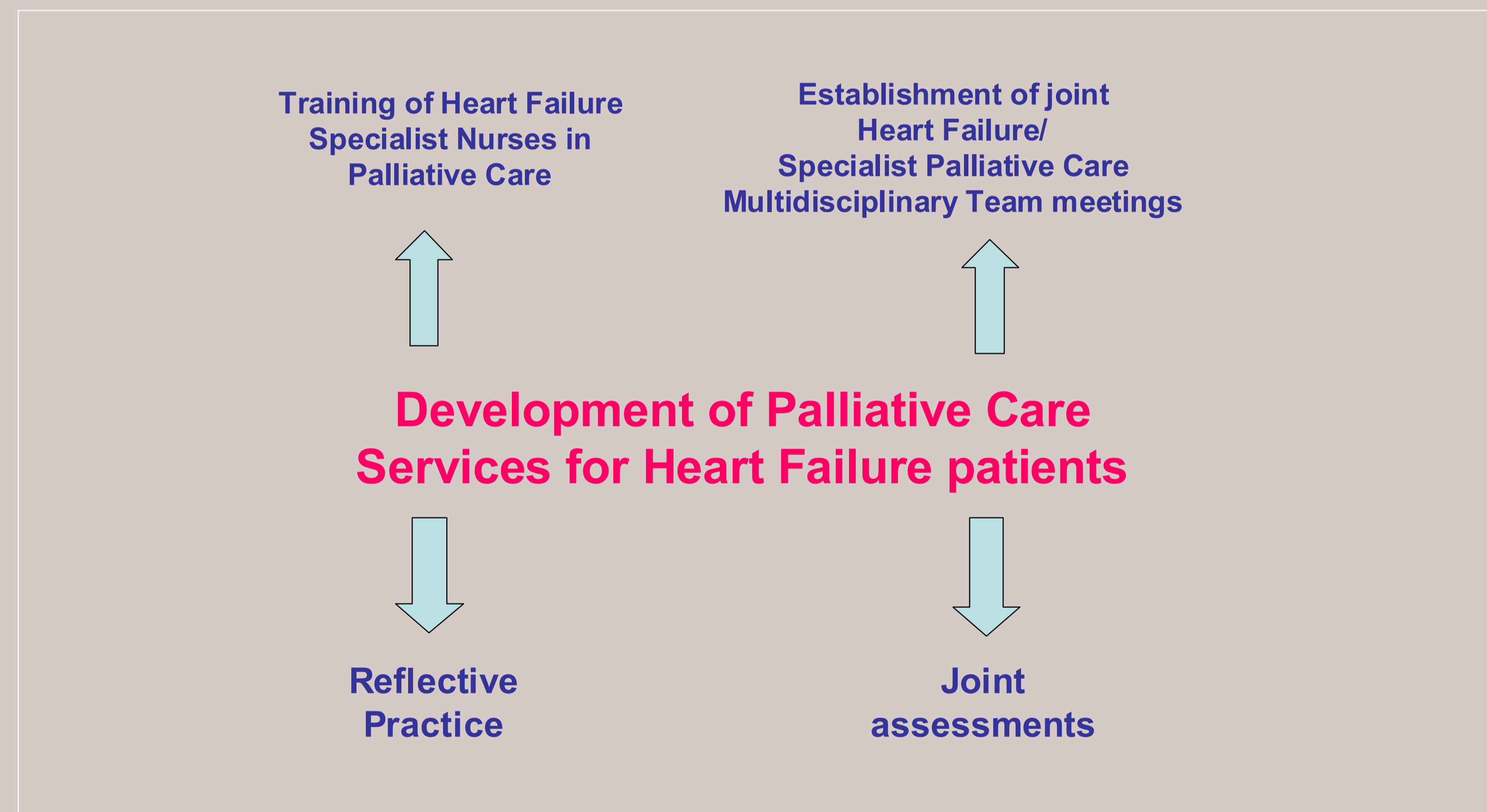
- Dr Aruna Hodgson, Consultant in Palliative Medicine was appointed in September 2005.
- Dr Sanjay Arya, Consultant Cardiologist with responsibility for Heart Failure, requested a meeting at an early stage to discuss possible service developments to address the recommendations of the NICE guidance.
- It was recognised that Specialist Palliative Care services could not address the palliative care needs of all the patients with Heart Failure.

## Training of Heart Failure Specialist Nurses in Palliative Care

- 3 community Heart Failure nurses appointed autumn 2005
- Underwent training in palliative care as part of their induction
- 6 x 2 hour sessions conducted by experienced palliative care educator
- Topics covered
  - Experience of loss & theories of grief
  - Advanced communication skills including
    - Breaking bad news
    - Handling collusion
    - Responding to difficult questions & strong emotions
  - Ethical issues in palliative care
  - Management of symptoms e.g. pain, breathlessness, anxiety, nausea & vomiting

## Establishment of joint Heart Failure/ Specialist Palliative Care Multidisciplinary Team meetings

- Commenced January 2006
- Held every 3 months at the Hospice
- Allow
  - Discussion of mutual patients
  - Discussion of complex patients
  - Planning of appropriate care – joint assessments, access to hospice services
  - Education



## Reflective Practice

- The Heart Failure Specialist Nurses have been exploring end-of-life issues with their patients with increasing frequency.
- The need was identified for reflective sessions, to support them in dealing with these issues.
- These were facilitated by experienced Specialist Palliative Care professionals, until the Heart Failure Specialist Nurses felt confident to take this forward themselves.
- The sessions have aimed to ensure best practice & allow further development of skills.

## Joint assessments

- Where possible, patients referred for hospice services have been assessed jointly by a member of the Specialist Palliative Care Team with the individual's Heart Failure Nurse, to enable development of a shared management plan and mutual learning.

## What can Wigan Specialist Palliative Care Services offer to patients with Heart Failure?

- **Hospice**
  - Inpatient care (12 beds)
  - Day Hospice
  - Complementary therapies
  - Counselling
- **Community Palliative Care Team**
  - Advice re symptom control, psychological support, & end of life care for patients at home
- **Hospital Palliative Care Team**
  - Advice re symptom control, psychological support & end of life care for patients in hospital
- **Palliative Care Outpatient Clinics**
  - Medical review for those with complex symptoms

## The Way Forward

- We are gradually extending the model developed for patients with Heart Failure to try and address the palliative care needs of patients with other non-malignant diseases
- Specialist Palliative Care services have developed links with other services
  - Joint MDT meetings with Chronic Kidney Disease service commenced February 2007
  - First joint MDT meeting with non-malignant respiratory disease teams held September 2007
  - Joint MDT meetings with services caring for patients with progressive neurological conditions being planned to start late autumn 2007

## Conclusion

- Over the past 2 years, we have made significant progress in addressing the palliative care needs of patients with non-malignant disease in Wigan
- The process has been very challenging for many members of the Specialist Palliative Care team
- So far, the need for direct involvement of Specialist Palliative Care services has been managed within existing resources
- We are still learning!

## References

1. Management of chronic heart failure in adults in primary and secondary care. National Institute for Clinical Excellence. July 2003
2. McCarthy M, Lay M, Addington-Hall JM. Dying from heart disease. J R Coll Physicians 1996 30:325-8