Guidelines for the referral of patients with chronic heart failure to the Palliative Care Team

Chapter Six of the National Service Frameworks (1) (NSF) for Coronary Heart Disease addresses Heart Failure. The aims of this Chapter include "Help people with unresponsive heart failure receive appropriate palliative care support" - this document has been prepared to facilitate that need.

These guidelines have been written to assist Doctors, and allied professions, when deciding which patients to refer to the Palliative Care Team.

The palliative care team can be accessed using the attached "flow chart".

The referring of patients to the Palliative Care Team will always remain at the discretion of the clinician involved in the case. If they require assistance or specialised in-put from the Palliative Care Team these guidelines aim to facilitate successful referral.

Those patients who may benefit from the Palliative Care Team's specialised skills would be those with one or more of the following;

- Severe class IV NYHA(2) chronic heart failure. This group of patients would have maximised medication but still have marked symptoms of heart failure.

- Repeatedly admitted with acute heart failure, despite maximised treatment. Any patients admitted 4 or more times per annum for decompensated chronic heart failure should be considered for referral to the Palliative Care Team. If not, reasons for not referring should be documented.
  N.B these patient may be grade III on discharge, but obvious recurring symptoms of this degree *may* indicate severe disease.
  Non compliance in this group of patients should also be considered.

- End stage cardiac failure or "unresponsive heart failure" (1) for whom re-admission to the District General Hospital may not be the best or only options. Therefore direct admission from home to the hospice where specialist nursing and medical attention could be given to both patient and carer could be considered.

- End stage cardiac failure or "unresponsive heart failure" (1) for whom re-admission to the District General Hospital may not be the best or only option. Therefore with full agreement with family and primary care physician some patients will request to stay at home in the last stages of their illness. The Community Palliative Care Team would be able to support these patients where appropriate.

- Conditions where their outcomes are unpredictable, even unknown. Such patients may benefit from the counselling and support networks provided by the Palliative Care Team.

- Would benefit from the day care services offered by the hospice on an individual basis, if required.

Patients and carers wishes must always be considered and full verbal consent must be obtained before any patient is referred.

References:

1) National Service Framework Chapter Six Heart Failure. Crown Copyright Produced by the DOH

2) New York Heart Association Functional Classification Goldman Hashimoto Cook Loscalszo (1981): Circulation 64: 1227

I	No Symptoms
II	Symptoms only with moderate activity
III	Symptoms with mild activity greater than ADL
IV	Symptoms at rest excluding PND

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