

Can Palliative Care for Heart Failure be Indicated in the Emergency Department?

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Introduction

Heart failure (HF) is a progressive disease marked by a pattern of gradual decline interspersed with episodes of acute deterioration. This often culminates in either sudden death or hospitalization.¹⁻³ Discussing its trajectory, especially in emergency decompensations, can be challenging when physicians predict these situations using palliative care (PC) principles and practices.^{4,5}

The World Health Organization defines PC as a patient and family-centered approach aimed to enhance the overall quality of life (QoL) by proactively addressing, preventing, and alleviating suffering.⁶ This prioritizes relief of pain and management of distressing symptoms, upholds life's value, and recognizes the natural process of dying. PC also provides a support system, empowering patients to live as fully and actively as possible until the end of life (EoL).^{6,7}

Compounding this issue, there is a prevailing tendency, shared by patients, families, and even healthcare professionals, to view “stable” HF patients as less susceptible to death or hospitalization. Consequently, clinicians often avoid discussing the possibility of these events, leading to situations where patients suddenly present at emergency departments with acute HF exacerbations. The decision-making process in these critical moments can be fraught with anxiety for everyone involved.^{1,7}

What do the Guidelines say?

In 2009, the European Society of Cardiology (ESC) defined three stages in progressive HF and PC goals in each stage.⁸ The Brazilian Society of Cardiology, in 2018, stated that the multidisciplinary team caring for HF patients should implement PC early and increase PC actions as the disease progresses.¹ In 2020, the ESC specified components of symptoms alleviation, spiritual and psychosocial support, and the appropriate modifications of guideline-directed treatment protocols,

including drug deprescription and device deactivation, for the chronic, acute crisis, and terminal phases of HF.⁷(Figure 1)

PC is founded in a teamwork spirit, structured with a focus on this central mission. This plan must be thoughtfully tailored to patients' unique values, preferences, and aspirations, ensuring a comprehensive approach covering all well-being aspects, especially near terminal phases. Core principles encompass patient-centered and family/caregiver-centered care, enhancement of QoL, effective and empathetic communication, collaborative decision-making concerning treatment choices, advanced care planning, and holistic consideration of patient's physical, emotional, spiritual, and psychological needs. Furthermore, it needs the active involvement of the patient's support system and family in assessing and managing care. The expertise of PC specialists must be seamlessly integrated into the collaborative efforts of primary care teams to provide patients with the best as possible care.^{6,8}

The 2021 ESC HF Guidelines discussed the signs of EoL in HF.² (Figure 2) Several components of PC demand special attention when dealing with advanced HF. First and foremost, the focus should remain steadfastly on improving or preserving the patient's QoL, striving to maximize it until the end. Another essential aspect is the ongoing and vigilant assessment of symptoms, including dyspnea and pain, which can arise from HF itself or concurrent comorbidities.⁷⁻⁹

Advanced care planning plays a critical role, encompassing discussions regarding patient's preferences for the location of their eventual passing, decisions regarding the deactivation of devices (such as cardiac defibrillators), and involving a multidisciplinary team to ensure that all aspects of care are coordinated and aligned with the patient's wishes.^{1,7-9}

How can we implement PC in the Emergency Room?

Implementing PC upon admission to the emergency room (ER) is an important but essential challenge to improve the QoL of patients in advanced disease stages. Some ER professionals opine that it would not be the appropriate place for terminally ill patients, nor the right location to begin a PC's journey. This raises the misperception that providing this type of care in the ER is inadequate. However, ERs often represent the first point of contact for patients in crisis, including those with limited life expectancy, and providing patient-centered care in this setting can help them achieve their care goals.⁹⁻¹¹

Establishing protocols to identify patients who can benefit from PC and begin it is necessary. ER staff should be trained in basic PC skills such as symptom management, communication, and advanced care planning.⁹⁻¹²

Keywords

Palliative Care; Heart Failure; Emergency Medical Services.

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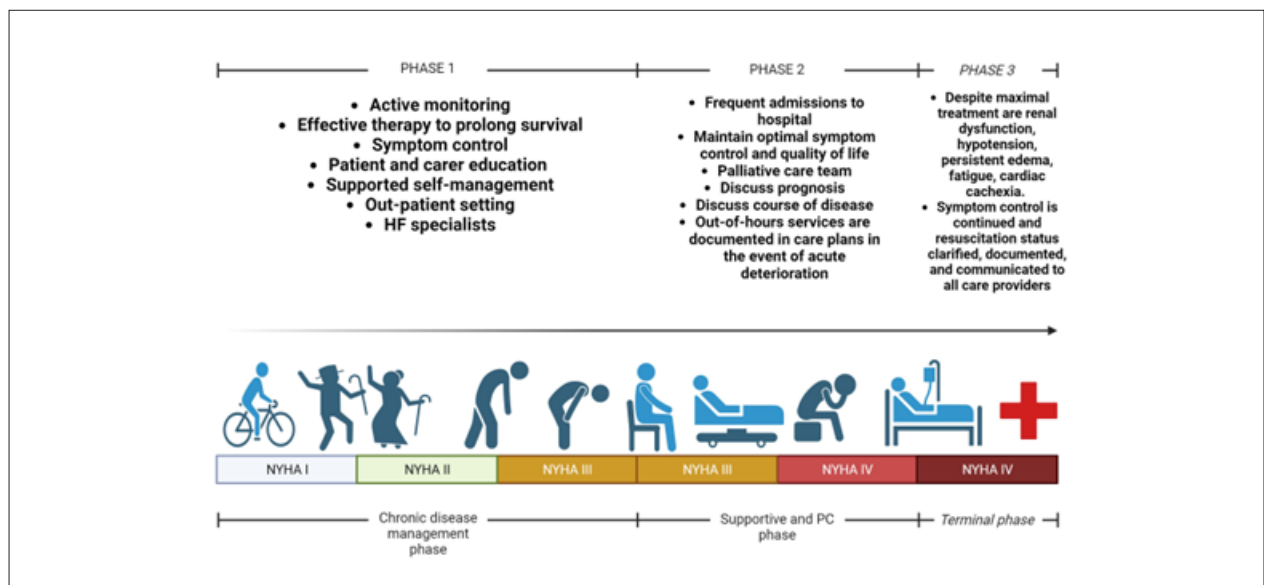


Figure 1 – Phases and goals of PC in HF

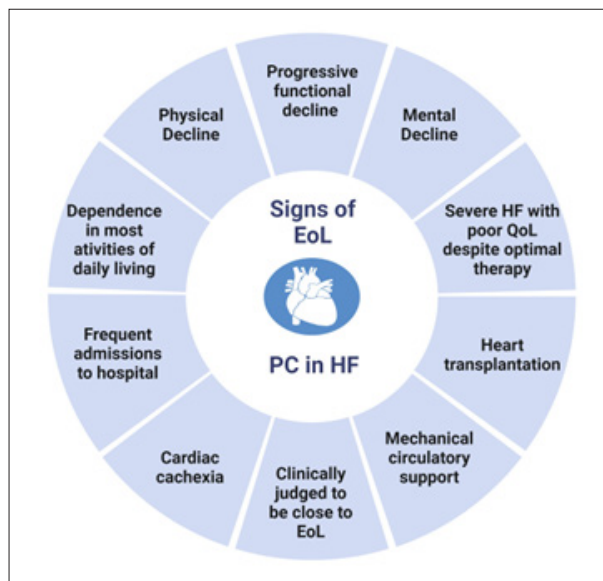


Figure 2 - HF and signs of end-of-life.

A Canadian study demonstrated that HF patients aged 65 or older who seek ER have a low PC involvement rate of 15.8%. Furthermore, only 41% of all deceased patients after one year had any PC involvement. Of those who received PC, 76% had less than two weeks of involvement before death. The study suggests that the ER could be an appropriate place to identify and refer high-risk HF patients who could benefit from earlier PC involvement.¹³

A valuable tool is the Health-Related Quality of Life (HRQoL) questionnaire, which assesses an individual's perception of their physical, emotional, and social well-being concerning their health and medical treatment. Patients

with advanced cardiovascular diseases (ACVD) experience lower HRQoL due to their illness's physical and emotional burden. Caregivers, including family members and healthcare professionals, play a critical role in supporting patients with ACVD. Caregivers can help manage symptoms, provide emotional support, and assist in making decisions related to medical treatment and EoL care. However, caregiving can also be a source of stress and burden, and caregivers may face their own challenges in terms of physical and emotional health.¹⁴

Limitations and Challenges for PC in the ER

The main challenges include (1) early identification of patients who would benefit since the primary focus is on acute stabilization; (2) effective communication; (3) lack of training; (4) family members may not be prepared to discuss PC, make difficult decisions, or may have unrealistic expectations regarding treatment, especially during an acute decompensation episode; (5) limited resources, such as access to PC teams or specific medications; (6) care coordination. Overcoming these limitations is crucial to ensure patients receive appropriate and compassionate care.^{1,8-11}

Steps to Be Established in the Assessment of PC in HF Patients in the ER

We suggest the steps below for patients with HF that can be applied in the ER.^{1-3,7-12}

1. **Comprehensive Assessment:** Conduct a thorough patient assessment, including the severity of HF, comorbidities, symptoms, medical history, and, especially, the patient's goals and preferences regarding medical care. This helps determine if a PC is appropriate.

2. **Effective Communication:** Maintain open and empathetic communication with patients and families. Explain clearly disease progression and available treatments, including PC.

3. Symptom Assessment: Identify and assess the patient's symptoms, such as dyspnea, pain, fatigue, and anxiety.

4. Symptom Control: Administer appropriate treatments to alleviate symptoms, ensuring comfort and the best as possible QoL.

5. Advance Care Planning with patient and family: This involves identifying the patient's preferences regarding cardiopulmonary resuscitation, invasive interventions, and EoL care.

6. Consultation with Specialists: If necessary, refer the patient for consulting the PC care team to provide specialized support.

7. Emotional Support: Offer to patient and family, as dealing with a severe illness can be emotionally challenging.

Conclusion

In essence, PC principles should be integrated into the care of HF patients from the outset to enhance their overall well-being, alleviate suffering, and facilitate clear communication about disease progression and potential outcomes.

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Ethics approval and consent to participate

This article does not contain any studies with human participants or animals performed by any of the authors.



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