Abstract: 1334

Heart failure and palliative care: an integrated service for patients across hospital and community settings

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Background:
Effective integration of care across care settings and between clinical teams is essential to improve patient reported outcomes and resource use. We evaluate a new integrated clinical service for patients with end-stage heart failure (HF) palliative care (PC) needs.

Method:
Six GP practices referred patients over 1 year. Patients were assessed and followed up by an Advanced Nurse Practitioner (ANP). The ANP worked closely with cardiology consultants and HF/PC hospital teams, the Community PC Team and primary care colleagues. Following initial assessment, patients were discussed at joint multidisciplinary team meetings (MDM) to assess both cardiac and palliative needs. Patient reported outcomes included the Integrated Palliative Care Outcome Scale (IPOS) and quality of life (QUAL).

Results:
102 patients, mean age 84.2 ± 10.2 years, were referred, 89 were accepted onto the pilot. 55 (61.8%) had left ventricular systolic dysfunction (LVSD), 14 (15.7%) patients had HF with preserved ejection fraction, 13 (14.6%) had predominately valvular dysfunction, 5 (5.6%) had right sided HF. This frail, elderly population had multiple co-morbidities.

44% of patients died during the 18 month pilot period; 69% at home/hospice versus 31% in hospital. For most patients, preferred place of care and death were home. Compared with the year pre-pilot, we demonstrated a 36% reduction in hospital admissions with 51% reduction in hospital bed days. There was a 9% increase in A&E attendances, but the proportion attending for cardiac reasons reduced (20% versus 13%). Actions from the MDM meetings included almost a half of patient’s having cardiac medications titrated and a quarter had other medications titrated to aid symptom control. Joint decisions regarding switching or stopping anticoagulation were key. A small number of patients received hand held echocardiography and assessment at home by the cardiology consultant or were treated with subcutaneous Furosemide in the home setting, both to guide management and avoid hospital admissions where preferred place of care was home. The pilot supported integrated care across settings including referrals to hospice (inpatient admissions, breathlessness management service, living well at home), Community Services (District nurses, OT and Physio, Respiratory nurses). Ongoing carer support from the ANP was key.

IPOS improved over time in 55% of patients; declined in 40% and the remainder stayed the same. Views on Care showed that in 82% of assessments support from the palliative care service had made a benefit and patients reported a significant improvement in QUAL (p<0.001, 7 point Likert scale).

Conclusion:
This model of care has had significant benefits in reducing hospital bed days and admissions, increasing patients dying outside of hospital, providing timely support and care to improve symptoms and wellbeing for palliative patients (and their carers) with end-stage heart failure.