

Integrating Palliative Care Into Heart Failure Management

Rebecca (Schuetz) Bierle, MSN, APRN
Karen M. Vuckovic, PhD, APRN
Catherine J. Ryan, PhD, APRN, CCRN-K

BACKGROUND The World Health Organization defines palliative care as an approach that improves the quality of life of patients and their families through the prevention and relief of suffering by assessment and treatment of physical, psychosocial, and spiritual problems. Any patient with chronic debilitating disease, including heart failure, is a candidate for interdisciplinary palliative care to manage their complex physical and psychosocial needs.

CLINICAL RELEVANCE The philosophy of palliative care has evolved to include a vision of holistic care extended to all individuals with serious illness and their families or caregivers that should be integrated throughout the continuum of care, including the acute phase. The critical care nurse will likely encounter patients with heart failure who are receiving or are eligible to receive palliative care at various time points during their illness. Critical care nurses therefore play a pivotal role in symptom palliation affecting the heart failure patient's quality of life.

PURPOSE To review the models of palliative care and the role that the critical care nurse plays in symptom palliation and preparation of the patient and their family for transition to other levels and settings of care.

CONTENT COVERED This review addresses the principles and models of palliative care along with how to integrate these principles into all phases of the heart failure disease continuum. Also included are recommendations for palliation of symptoms specific to heart failure patients as well as a discussion of the role of the critical care nurse and the importance of shared decision-making. (*Critical Care Nurse*. 2021;41[3]:e9-e18)

All heart failure (HF) patients are candidates for interdisciplinary palliative care to manage their routine physical and psychosocial needs. Hospitalization and treatment in the intensive care unit (ICU) for acute HF are critical events in the disease trajectory of HF when palliative care should be considered.¹ Palliative care for HF patients is an emerging field with limited studies that specifically address this population. The purpose of this article is to provide an overview of palliative care in the ICU or progressive care unit for patients with HF.

The World Health Organization defines palliative care as an approach that improves the quality of life (QOL) of patients and their families through the prevention and relief of suffering by assessment and treatment of physical, psychosocial, and spiritual problems.² Palliative care can be delivered by a trained palliative care specialist or any clinician who is competent in palliative skills.³ The level of palliative care

services varies by site, with more than 65% of hospitals in the United States providing specialty palliative care to inpatients.⁴ In addition, outpatient programs are emerging as ways to provide palliative care longitudinally and across settings.⁵

Palliative care is an important component of the holistic treatment of patients with advanced HF and improves QOL.⁶ The National Institute for Nursing Research recognizes palliative care as a critical component of high-quality, evidence-based health care that improves the QOL of those with a serious illness.⁷ This coordinated approach is recommended by major professional cardiovascular⁸⁻¹⁰ and critical care societies for advanced HF treatment.¹¹

Acute exacerbations of HF can lead to admission to critical or progressive care units, where the mortality risk increases with each hospitalization.¹² Despite the increased mortality risk, only 6% of patients admitted for HF receive a palliative care consultation.¹³ Every hospital admission for acute HF is an opportunity for the critical care nurse to review and recalibrate goals of care with the patient and the patient's caregiver(s) throughout admission and during discharge planning to achieve positive patient outcomes and relieve symptom distress.¹⁴

Principles of Palliative Care and Corresponding Actions

Palliative care is patient- and family-centered care that optimizes QOL by anticipating, preventing, and treating suffering. Palliative care can be integrated into the early care of all patients with advanced HF and delivered in tandem with aggressive care.¹⁵ Kavalieratos and colleagues¹⁴ have suggested that palliative care principles

be integrated throughout the HF management continuum of care, including the acute phase in the ICU or progressive care units.

The importance of offering the palliative care option to patients has been increasingly recognized within the HF community. The American College of Cardiology (ACC) has provided several tools to help the cardiovascular team integrate palliative care into their practice. The Improving Palliative Care in the ICU Advisory Board provides specific evidence-based recommendations for nurses for assessment and intervention related to the most common and distressing symptoms in ICU patients.¹⁶ The Improving Palliative Care in the ICU website (www.ccapc.org/toolkits/integrating-palliative-care-practices-in-the-icu) includes a program to assist in integrating palliative care in the ICU by training bedside nurses on certain skills such as communication about serious illness.¹⁷ A total of 7 core principles and corresponding actions to guide clinicians through the palliative care process and the transition to hospice for patients with HF with reduced ejection fraction are summarized in Table 1.

Models of Care

Various organizations have adopted different models of palliative care, depending on the resources available at the facility implementing the model. The most common models include integrated,^{15,20} interdisciplinary specialty,¹⁵ consultative,²⁰ and blended¹⁵ or combined.²⁰ In the integrated model, the unit care team provides palliative care as part of usual care.^{15,20} The interdisciplinary specialty or consultative model includes a palliative care consultant or team that directs palliative care in collaboration with the usual care team.¹⁸ The blended or combined model incorporates elements of both models, based on needs and facility resources.²⁰ Any of these models can be integrated across the continuum of HF care.

Integrating Palliative Models of Care Across the HF Continuum

For many years, palliative care was seen as a separate service or designated team that supplemented traditional, physiological symptom-based care.²¹ More recently, the philosophy of palliative care has evolved to include a vision of holistic care extended to all individuals with serious illness, including HF patients and their families or caregivers²² across the continuum of the disease²¹

Authors

Rebecca (Schuetz) Bierle is a nurse practitioner in cardiology, Monument Health Heart and Vascular Institute, Rapid City, South Dakota.

Karen M. Vuckovic is a clinical associate professor, College of Nursing, Department of Biobehavioral Health Sciences, University of Illinois at Chicago; and an advanced practice nurse, Division of Cardiology, University of Illinois Hospital and Health Sciences System, Chicago.

Catherine J. Ryan is a clinical associate professor, College of Nursing, Department of Biobehavioral Health Sciences, University of Illinois at Chicago.

Corresponding author: Catherine J. Ryan, PhD, APRN, CCRN-K, College of Nursing, Department of Biobehavioral Health Science, University of Illinois at Chicago, 845 S Damen Ave (MC 802), Chicago, IL 60612 (email: cryan4@uic.edu).

To purchase electronic or print reprints, contact the American Association of Critical-Care Nurses, 27071 Aliso Creek Rd, Aliso Viejo, CA 92656. Phone, (800) 899-1712 or (949) 362-2050 (ext 532); fax, (949) 362-2049; email, reprints@aacn.org.

Table 1 Palliative care principles and corresponding actions

Palliative care principle ^{9,18}	Action ^{6,9,11,14,19}
Reduce suffering, relieve pain and other distress symptoms while integrating psychological and spiritual aspects of care.	Promote QOL and relieve suffering. Psychosocial issues are important considerations in patients being evaluated for a transplant or mechanical circulatory support.
Optimize the management of symptoms.	Continue to meticulously manage HF symptoms throughout life, including the use of diuretics when needed.
Consult the palliative care team to help ameliorate refractory symptoms of dyspnea, fatigue, and pain.	Initiate an interdisciplinary palliative care consultation to aid with complex decisions, refractory symptoms, end-of-life care, and preparedness planning. Solicit caregiver participation.
Provide the patient with support as they think through the benefits and burdens of major treatment decisions.	Use decision support tools to present personalized options and aid discussion. Identify medical decision maker by day 2 of hospitalization.
Attempt to simplify difficult future decisions using proactive preparedness planning discussions.	Discuss clinical status, current therapies, and prognosis, and clarify patient beliefs and values. Determine resuscitation status by day 2.
Monitor the patient's clinical trajectory and, when necessary, adjust expectations and guide decisions but acknowledge that prognostic uncertainty is inevitable.	Acknowledge that triggers of disease progression such as kidney dysfunction, medication intolerance, and hospitalizations are inevitable but the clinical course and how much time remains are unpredictable. Patients with progressive symptoms who request all therapies may decide to forgo LVAD therapy.
Transition to comfort only; may be preceded by a time in which patients weigh the benefits, risks, and burdens of continuing to pursue life-sustaining treatment.	Revise the treatment plan to continue therapies for symptom relief such as nebulized furosemide and opioids for refractory dyspnea and withdraw other therapies such as intravenous inotropes, defibrillation, and mechanical circulatory support.

Abbreviations: HF, heart failure; LVAD, left ventricular assist device; QOL, quality of life.

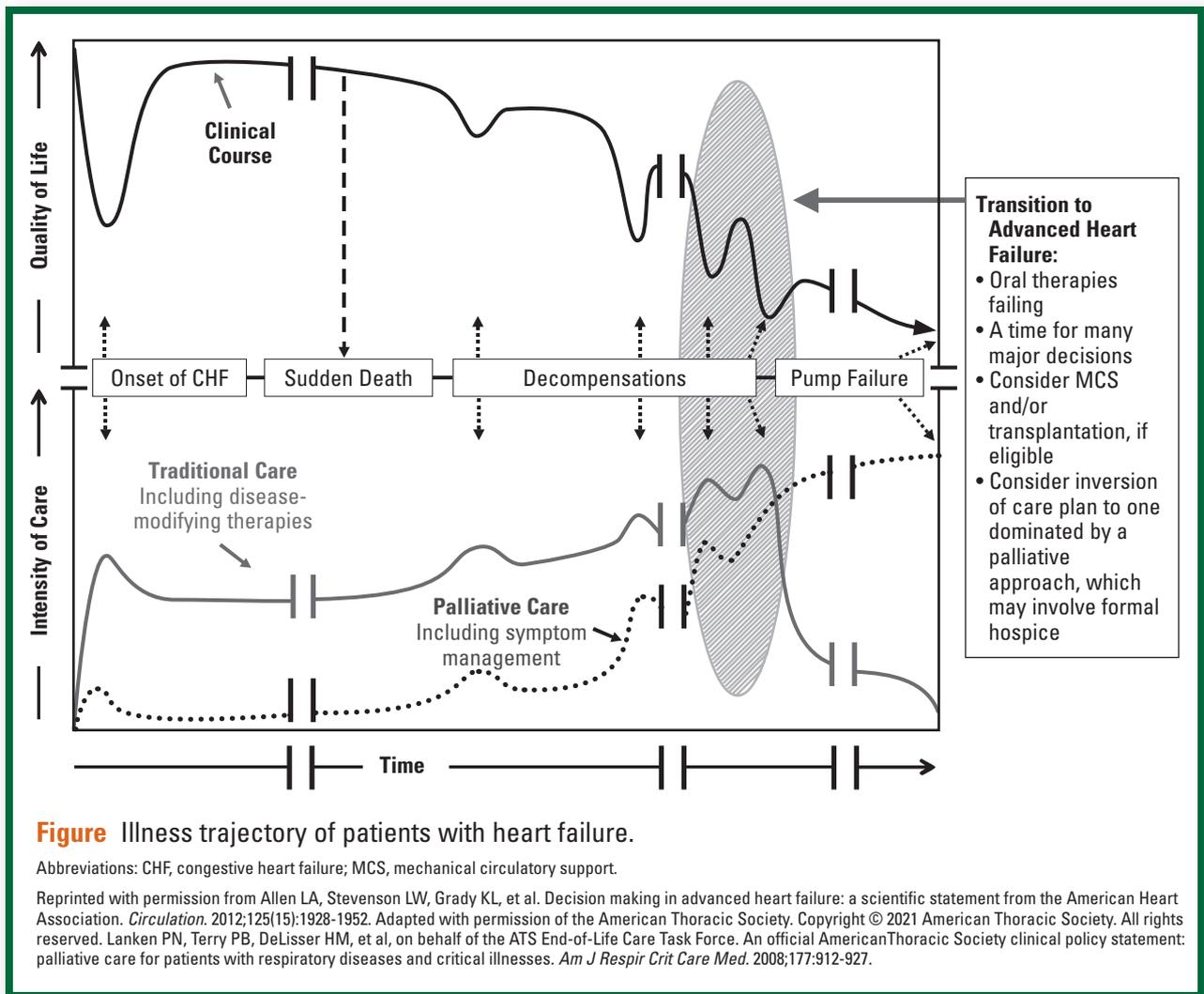
wherever care is provided.²² Palliative care can include aggressive treatment for symptom palliation and potentially aggressive medical therapies.

The unpredictable but overall progressively declining illness trajectory of patients with HF (see Figure) makes palliative care ideal because it does not depend on the prognosis and can be integrated into all phases of the patient's treatment and disease. However, the intensity of palliative care and types of palliative care provided can vary throughout the trajectory of the disease.¹⁸

Nurses can provide "primary palliative care" while physicians and advanced practitioners with specialized training in palliative care provide "secondary palliative care."¹ Primary palliative care is incorporated into many aspects of nursing care that is provided by critical care nurses, including symptom management, medication management, goals of care, and promoting QOL.⁸ When HF progresses to a more complex level, specialized services (if available) can be added by consulting with clinicians with training to provide supportive care that includes physiological, psychosocial, functional, social, ethical/legal, and financial concerns as well as complex symptom management, complicated advance care planning, or difficult decision-making.^{8,18,22}

When to make the transition from primary palliative care to use of a specialized palliative care team continues to be debated in the literature. In a recent review, Slavin and Warraich¹ suggested 3 points in the disease trajectory at which specialized services would be most beneficial: (1) when there is development of poor prognostic signs in the outpatient setting, typically New York Heart Association class III to IV; (2) at the time of hospitalization or ICU admission; and (3) at the time of evaluation for left ventricular assist device (LVAD) placement, ablation for refractory ventricular dysrhythmias, or valvular procedures.

More than half of hospitals with 50 or more beds have a designated palliative care program, according to the 2015 Palliative Care Report Card.²³ However, critical care nurses who work at hospitals without a palliative care program can still provide primary palliative care, such as symptom assessment and management along with goal setting according to the patient's wishes and beliefs. In addition, the critical care nurse can provide the patient and their family members with community-based resources for when the patient is discharged. Hospice care is indicated for patients whose life expectancy is less than 6 months²² and is intended to provide



comfort and maximize QOL without life-prolonging treatments.^{24,25} The key elements of care for acute HF, palliative care, and hospice care are compared and presented in Table 2.

Symptom Palliation

Physiological symptoms may arise from HF itself, treatment for HF, or comorbidities. Patients with HF commonly experience refractory dyspnea, depression, edema, pain, and fatigue, which can contribute to spiritual distress. Other symptoms include nausea, thirst, cognitive impairment, weakness, and anxiety. Patients with HF may experience an average of 9 to 12 symptoms.^{30,31} As HF progresses, symptoms become more severe, and symptom-related distress increases. The treatment goals are 2-fold: relieve symptom burden and consider discontinuing agents that do not provide symptom relief.²⁴

Dyspnea

Dyspnea is one of the most common and burdensome symptoms of HF and is prevalent in critically ill patients in the ICU. It can be one of the most challenging symptoms to address when delivering palliative care. *Dyspnea* is defined by the American Thoracic Society as the “subjective experience of breathing discomfort that consists of qualitatively distinct sensations that vary in intensity.”^{32(p246)} The frequency and severity of dyspnea increase as HF progresses; the prevalence of dyspnea in end-stage HF has been reported to be as high as 88%.³¹ Initial steps in managing dyspnea in the acute setting center on decreasing pulmonary congestion through intravenous diuretics, inotropes, vasodilators or vasopressors, and invasive or noninvasive mechanical ventilation.^{25,27} Opioids have been used successfully to reduce dyspnea through vasodilation and for a secondary antianxiety effect.^{33,34} Although oxygen is frequently

Table 2 Comparison among care for acute heart failure, palliative care, and hospice care

	Usual care for acute heart failure ^{10,26-28}	Palliative care ^{1,8,9,29}	Hospice care ^{8,10}
Definition	Rapid relief for increased symptoms with a decrease in functional status of at least 1 New York Heart Association functional class	Patient- and family-centered care that optimizes QOL by anticipating, preventing, and treating suffering	Specific type of palliative care providing medical, emotional, and spiritual support, focusing on improving patient and family QOL
Timeline	De novo event or any time after initial diagnosis resulting in admission	Any time during the continuum of disease and when there are critical changes in therapy LVAD evaluation Hospital discharge on inotropes	Provides care for those with a life expectancy measured in months
Care setting	ED, ICU, progressive care	In any care setting	Home (majority), nursing homes, residential facilities, hospital, hospice facilities
Clinical situation	Rapid onset or acute worsening of symptoms associated with elevated natriuretic peptides Hypotension associated with poorer outcomes	Life-limiting nonterminal illness Treat symptoms with the potential to improve Non-prognosis-driven	Terminal illness Life expectancy less than 6 months Prognosis-driven
Indications	Provide aggressive care to reverse, stabilize potentially life-threatening event	Manage burdensome disease-modifying therapies delivered in tandem with aggressive therapy Manage persistent symptoms despite maximum therapy Presence of cardiac cachexia or weight loss $\geq 6\%$ total body weight	Provide comfort Avoid aggressive, expensive, futile care at the end of life
Goal	Optimize hemodynamics, provide adequate oxygenation, and relieve symptoms	Provide comfort and treat symptoms	Facilitate a comfortable and dignified death
Skills/action			
Reimbursement	Private insurance Medicare Part A	V code ^a	Private insurance Medicare Part A
Coverage	Comprehensive	Not comprehensive	Comprehensive

Abbreviations: AHF, acute heart failure; ED, emergency department; ICU, intensive care unit; LVAD, left ventricular assist device; QOL, quality of life.

^a V Code is part of the Patient Refined Diagnosis-Related Group system.

prescribed for dyspnea, supplemental oxygen may not alleviate the symptom, especially if hypoxemia is not present.^{14,35} Patients with advanced HF may experience dyspnea that becomes refractory to standard therapy; alternative treatments may help. In a systematic review, Qian et al³⁶ examined studies that evaluated the effectiveness of fan therapy (electric or handheld fan positioned to circulate cool air toward the patient's face) to manage dyspnea. The investigators concluded that the results were inconclusive owing to the poor quality and small number of studies.³⁶ Aerosolized furosemide has also been evaluated as a nonopioid treatment for refractory dyspnea. The results of the studies on this topic are mixed, with a wide variation in response, and this remains an area of ongoing research.³⁷

Depression

About 20% to 30% of patients with HF meet the criteria for depressive disorder, with a higher percentage reported for those with advanced HF.³⁸ Depressive symptoms are correlated with poor QOL and increased pain. Several clinical trials have evaluated the use of selective serotonin reuptake inhibitors (SSRIs) in HF. This class of antidepressants is commonly prescribed for patients with HF, and SSRIs have been found to have minimal cardiovascular side effects in patients without underlying heart disease. The Sertraline Against Depression and Heart Disease in Chronic Heart Failure (SADHART-CHF) study found that although sertraline did not have adverse cardiovascular effects compared with placebo, it also did not improve depression scores.³⁹ Likewise, Angermann

and colleagues⁴⁰ investigated the long-term efficacy and safety of escitalopram and did not find a significant improvement in depression or reduction in all-cause mortality or hospitalization compared with placebo. Consequently, escitalopram is not recommended for HF. To date, there is no conclusive evidence that HF patients receive benefits from antidepressants; therefore, they should be used only for patients who do not respond to supportive care or cognitive-behavioral therapy.⁴¹

Edema

Fluid retention, a hallmark finding of HF, is associated with dyspnea, cough, ascites, decreased appetite, and peripheral edema. Management includes optimizing traditional HF medications along with aggressive diuresis. Patients with an inadequate response to oral dose titration may receive an intravenous, a subcutaneous, or a

nebulized loop diuretic. If the condition has become refractory to stan-

There is no conclusive evidence that patients with heart failure benefit from taking antidepressants.

standard furosemide dosing, bumetanide or torsemide may provide additional benefit. The concomitant administration of metolazone, a thiazide diuretic, may enhance diuresis.⁴² Dual diuretic therapy mandates careful monitoring of the patient for orthostatic blood pressure changes and electrolyte abnormalities. Patients should avoid medications that cause sodium and fluid retention, such as nonsteroidal anti-inflammatory drugs and SSRIs.⁴² Importantly, patients may experience a sensation of fullness, which can affect their appetite. Nonpharmacological interventions include compression stockings, reduced-sodium diet, fluid restriction, and elevating the legs if pedal edema is present.³⁵ Ultrafiltration and consultation with a nephrologist may be considered for those whose edema is refractory to escalating doses of diuretics and medical therapies.¹⁰

Pain

Often, palliative care is discussed in the context of pain management. Pain, unlike dyspnea, has not always been routinely assessed in patients with HF. Several smaller studies have examined the incidence of pain and its relationship with other comorbidities. Goodlin and colleagues⁴³ enrolled patients ($n = 397$) with advanced HF in the Pain Assessment, Incidence, and Nature in HF

(PAIN-HF) study. Pain was a common complaint, especially at the end of life, with an incidence of 84%. Most often, pain is caused by other noncardiac conditions such as gout, osteoarthritis, or diabetic neuropathy, but pain did not predict QOL.^{43,44} Specific management of pain in advanced HF has not been well studied; however, given its prevalence, pain should be routinely assessed with careful attention to the source. The general principles of pain management should be followed, such as treatment with opiates, but caution should be used with methadone (which can prolong the QT interval) and nonsteroidal anti-inflammatory drugs (which can cause sodium and fluid retention and impair renal function).²⁵ Nonpharmacological evidence-based therapies for pain include biofeedback, meditation, relaxation therapy, and psychotherapy.⁴⁵

Other Symptoms

Patients may experience gastrointestinal symptoms (eg, dry mouth, nausea, thirst, constipation) and psychosocial issues (eg, anxiety or insomnia).^{14,25,42,46,47} Importantly, patients with cardiovascular disease may develop cachexia, which is associated with increased mortality, but few data are available to guide management of this condition.^{35,48} Cachexia is a metabolic wasting syndrome characterized by unintentional muscle mass loss, weight loss, and anorexia.⁴⁸ Approximately 10% of ambulatory patients with HF with reduced ejection fraction develop cachexia.⁴⁹ More research is needed to help guide management of cachexia for patients with HF.

Addressing Psychological and Spiritual Needs of Patients and Families

The National Consensus Guidelines for Quality Palliative Care⁵⁰ recommend developing a grief care plan and providing it to patients and their families. Another practice recommendation is to assess and manage psychological reactions of patients and their families, including stress, coping, and anticipatory grief, on an ongoing basis.⁵⁰ Critical care nurses observe patient and family interactions during their shift and often over the course of several shifts; thus, they have the opportunity to identify and address the patient's psychological issues, which might alter as circumstances change. For example, the critical care nurse can provide feedback to the palliative care team and reinforce education and coping mechanisms with the patient and the family.

Assessing spiritual needs of patients and their families contributes to a holistic approach to care. Unmet spiritual needs have been associated with decreased QOL.⁵¹ Praying with or for patients and singing spiritual songs are examples of spiritual nursing care interventions.⁵² Providing information or referrals are examples of spiritual care that nonreligious nurses can use.⁵²

Decision-Making

Decision-making starts with communication about the clinical situation and moves forward to care planning, in which patients incorporate their own care preferences.⁴⁷ Therefore, education and conversations related to a realistic understanding of disease progression and the variable trajectory of symptoms should occur as early as possible for patients with HF and their families and should continue throughout the course of HF treatment.^{29,53} In order to assist and support patients through the decision-making process, nurses should be aware of their own biases as well as the potential for moral distress while caring for these patients. Heart failure patients want to know their prognosis and what to expect. This information needs to be communicated early, while their cognitive function is intact, but the clinician must be careful to balance prognosis with hope for improved QOL.⁴⁷ Presenting all issues at one time would be overwhelming. Decisions about treatment options may not be relevant at each stage of the disease trajectory. As HF advances, topics that will need to be addressed and require patient or caregiver consent include symptom management, mechanical circulatory support, use of devices (cardiovascular implantable electronic devices [CIEDs]), LVADs, deactivation of devices, the financial burden of HF care, advance directives and resuscitation orders, and surrogate decision makers.⁴⁷ It is important that the critical care nurse realize and communicate to the patient that these decisions may change as their disease acuity changes.

Decision Support Tools

Every patient's symptom experience is different, but early assessment and intervention are critical to reducing suffering. A variety of decision support tools are available to assist with early assessment and intervention. The CARES tool provides prompts, in the form of an acronym, to address the most common symptom management needs of the dying, including comfort, airway management, restlessness and delirium, emotional

and spiritual support, and self-care.⁵⁴ Nurses receive prompts for implementation of actions, such as symptom management, and resources for support.⁵⁴

Advance directives clearly document the patient's wishes regarding end-of-life measures. Advance directives can include resuscitation preferences, CIED deactivation preferences, LVAD deactivation preferences,¹⁹ and preferences for QOL versus quantity of life.⁵⁵ The Heart Rhythm Society has issued a consensus statement on the management of CIEDs in patients nearing the end of life or requesting withdrawal of therapy.⁵⁶ This statement was developed in collaboration with the ACC, American Academy of Hospice and Palliative Medicine, American Geriatrics Society, European Heart Rhythm Association, American Heart Association, and Hospice and Palliative Nurses Association and provides guidance for clinicians on topics such as legal principles, proactive communication, and management options.

The landmark SUPPORT study of advance care planning interventions for advanced HF suggested that care providers need to proactively counsel and educate patients on advance directives.⁵⁷ In addition, patient preferences can change in response to disease progression, so it is important for the critical care nurse to review the patient's advance directives routinely. **Caregivers should be included as a part of the heart failure team.** The ACC offers clinical toolkits, including an Advance Care Planning Toolkit that contains 15 advance care planning metrics and strategies to support clinicians.⁵⁸ These can be found at cvquality.acc.org/clinical-toolkits. The goal of the Advance Care Planning Toolkit is to equip clinicians to understand and document advance care planning and integrate it into routine practice.⁵⁸ This evidence-based knowledge and tools for palliative care can assist the critical care nurse while caring for a patient with HF who might benefit from palliative care.

Family Caregiver Participation

Heart failure requires lifelong treatment. Family caregivers are an important component of supportive care⁵⁹ because they play a pivotal role in promotion of the patient's health and daily symptom management.⁶⁰ Depending on the patient's wishes, critical care nurses should include family caregivers in all patient education and decision-making, including plans for end-of-life

care, to ensure that they are comfortable with assessing and addressing the patient's needs and planning future care. Often, care becomes a burden not only for patients but also for their families and caregivers.⁸ As the patient's illness progresses, the burden on family caregivers can become overwhelming. Caregivers often neglect their own needs, including social and health needs, to focus on meeting the needs of the family member with HF.^{59,60} As a result, family caregivers may become isolated. To ease the burden of caregiving, the critical care nurse and the palliative care team should offer family caregivers support and straightforward information in an unhurried and caring manner.^{18,60}

Inpatient and Outpatient/Home-Based Settings for Palliative Care

Palliative care discussion, referral, and implementation can occur across a variety of settings, including inpatient, outpatient, and home-based settings. Clinical models of palliative care for patients with HF in each of these settings are beginning to emerge.

Sidebottom et al⁶¹ compared the impact of inpatient consultation by a palliative care team versus usual care for patients

Palliative care and aggressive care can be delivered in tandem.

with acute HF. They found statistically significant

improvements for all outcomes measured, including QOL and symptom burden.⁶¹ A multidisciplinary team should deliver comprehensive education, with nurses taking the lead.⁶² Including multidisciplinary support in inpatient discharge planning can significantly improve the patient's QOL and reduce readmission rates.⁶² Approaches to integrating palliative care in the inpatient setting could include palliative care training for nurses and automatic palliative care consultations before discharge for patients with HF who are at high risk for readmission and/or have advanced disease.⁶² As stated by Braun et al,^{8(pe215)}

Hospital policy and practices should coordinate care planning, treatment decision-making, and discharge planning processes for hospitalized patients to promote the development and modification of feasible care plans that reflect patients' palliative care needs and how these needs will be met during all transitions and in any new care settings.

Therefore, critical care nurses should strive to integrate aspects of palliative care when caring for patients with HF.

Referrals to community palliative care programs in the home, assisted living settings, and skilled nursing facilities can be initiated by providers in primary care settings, the hospital, and/or a palliative care clinic embedded within an advanced HF clinic.⁶³ The Palliative Care in Heart Failure (PAL-HF) study compared usual care versus usual care plus a 6-month outpatient interdisciplinary palliative care intervention.⁶ The intervention addressed physical and emotional symptoms, advance care planning, and spiritual concerns. The palliative care intervention was associated with clinically significant improvements in QOL at 6 months.⁶

Palliative care can also be implemented in a home-based setting. Brännstrom and Boman⁶⁴ compared usual care versus a palliative care intervention that included HF disease management and palliative care services delivered by an interdisciplinary team. Patients who received the intervention reported statistically significant improvements in QOL at 6 weeks but no effect on symptom burden.⁶⁴ In a transitional palliative care trial, patients recently discharged from the hospital were randomly assigned to receive either usual care or home visits and telephone calls.⁶⁵ The patients in the intervention group had significantly fewer hospital readmissions and higher satisfaction with their health care at 12 weeks. In addition, the intervention was associated with improved QOL and reduced symptom burden.⁶⁵

The evidence is generally consistent that a palliative care approach, in a variety of settings, improves patient outcomes such as QOL and symptom burden. There are limited data, if any, on palliative care interventions focused on patients with HF in the ICU. However, extrapolating from existing data, palliative care intervention is likely to be beneficial for patients with HF who are admitted to the ICU because these patients have a similar high risk of mortality.¹ Critical care nurses have the opportunity to discuss palliative care with patients with HF in the inpatient setting and coordinate transitions of care with providers in the outpatient setting during discharge planning.

Transition to Hospice Care

Management of HF requires integration of acute inpatient services, chronic outpatient services, and palliative care and end-of-life services. Hospice is a health

care model for patients with a terminal prognosis and focuses on care coordination, symptom management, and caregiver support (Table 2).⁶⁶ The 2013 American College of Cardiology Foundation/American Heart Association guideline for the management of HF suggests that patients with symptomatic advanced HF be referred for palliative care and supportive care to improve QOL, as well as hospice care (for end-of-life care) when appropriate.¹⁰

Clinical Implications for Critical Care Nurses

Critical care nurses will likely encounter patients with HF who are receiving or are eligible to receive palliative care. Critical care nurses play a pivotal role in symptom palliation, affecting the patient's QOL; therefore, they should be aware of the principles of palliative care, as well as the model(s) that their facility uses. Using decision support tools can help clarify patients' wishes and further guide the critical care nurse's plan of care. Actively involving family caregivers in all patient education and decision-making is important because family caregivers play a crucial role in supportive care. Critical care nurses have the opportunity to incorporate palliative care for HF patients in the inpatient setting but also should facilitate transitions of care to other care settings, such as outpatient clinics, throughout the discharge process.

Critical care nurses should examine their own implicit and explicit biases related to palliative care interventions. New evidence has emerged that some critical care nurses, especially those with less experience, may develop moral distress as a result of providing palliative care in the ICU setting.⁶⁷ Careful self-examination as well as participation in palliative care education may alleviate moral distress for critical care nurses. Lastly, critical care nurses should understand the difference between palliative care and hospice care and know when patients could benefit from a referral to hospice care for end-of-life care. **CCN**

Financial Disclosures
None reported.

See also

To learn more about palliative care, read "Rationale and Resources to Accelerate Advanced Practice Palliative Care Competency" by Koirala et al in *AACN Advanced Critical Care*, 2020;31(2):191-195. Available at www.aacnconline.org.

References

1. Slavin SD, Warraich HJ. The right time for palliative care in heart failure: a review of critical moments for palliative care intervention. *Rev Esp Cardiol (Engl Ed)*. 2020;73(1):78-83.
2. World Health Organization. WHO definition of palliative care. 2019. Accessed February 19, 2019. <https://www.who.int/cancer/palliative/definition/en>
3. Quill TE, Abernethy AP. Generalist plus specialist palliative care—creating a more sustainable model. *N Engl J Med*. 2013;368(3):1173-1175.
4. Dumanovsky T, Augustin R, Rogers M, Lettang K, Meier DE, Morrison RS. The growth of palliative care in U.S. hospitals: a status report. *J Palliat Med*. 2016;19(1):8-15.
5. Meier DE, Beresford L. Outpatient clinics are a new frontier for palliative care. *J Palliat Med*. 2008;11(6):823-828.
6. Rogers JG, Patel CB, Mentz RJ, et al. Palliative care in heart failure: the PAL-HF randomized, controlled clinical trial. *J Am Coll Cardiol*. 2017;70(3):331-341.
7. National Institute of Nursing Research. NINR's palliative care brochure. Accessed April 28, 2019. <https://www.ninr.nih.gov/newsandinformation/publications/palliative-care-brochure>
8. Braun LT, Grady KL, Kutner JS, et al. Palliative care and cardiovascular disease and stroke: a policy statement from the American Heart Association/American Stroke Association. *Circulation*. 2016;134(11):e198-e225. doi:10.1161/CIR.0000000000000438
9. Yancy CW, Januzzi JL Jr, Allen LA, et al. 2017 ACC Expert Consensus Decision Pathway for optimization of heart failure treatment: answers to 10 pivotal issues about heart failure with reduced ejection fraction. *J Am Coll Cardiol*. 2018;71(2):201-230.
10. Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA guideline for the management of heart failure. *Circulation*. 2013;128(16):e240-e327. doi:10.1161/CIR.0b013e31829e8776
11. Aslakson RA, Curtis JR, Nelson JE. The changing role of palliative care in the ICU. *Crit Care Med*. 2014;42(11):2418-2428.
12. Yim CK, Barrón Y, Moore S, et al. Hospice enrollment in patients with advanced heart failure decreases acute medical service utilization. *Circ Heart Fail*. 2017;10(3):e003335. doi:10.1161/CIRCHEARTFAILURE.116.003335
13. Greener DT, Quill T, Amir O, Szydłowski J, Gramling RE. Palliative care referral among patients hospitalized with advanced heart failure. *J Palliat Med*. 2014;17(10):1115-1120.
14. Kavalieratos D, Gelfman LP, Tycon LE, et al. Palliative care in heart failure: rationale, evidence, and future priorities. *J Am Coll Cardiol*. 2017;70(15):1919-1930.
15. Munro CL, Savel RH. Aggressive care and palliative care. *Am J Crit Care*. 2018;27(2):84-86.
16. Puntillo K, Nelson JE, Weissman D, et al. Palliative care in the ICU: relief of pain, dyspnea, and thirst—a report from the IPAL-ICU Advisory Board. *Intensive Care Med*. 2014;40(2):235-248.
17. Center to Advance Palliative Care. Integrating palliative care practices in the ICU. 2019. Accessed April 20, 2020. <https://www.capc.org/toolkits/integrating-palliative-care-practices-in-the-icu>
18. Hupcey JE, Kitko L, Alonso W. Palliative care in heart failure. *Crit Care Nurs Clin North Am*. 2015;27(4):577-587.
19. Schaefer KG, Griffin L, Smith C, May CW, Stevenson LW. An interdisciplinary checklist for left ventricular assist device deactivation. *J Palliat Med*. 2014;17(1):4-5.
20. Harman SM. Psychiatric and palliative care in the intensive care unit. *Crit Care Clin*. 2017;33(3):735-743.
21. Hupcey JE. The state of palliative care and heart failure. *Heart Lung*. 2012;41(6):529-530.
22. National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care. 4th ed. 2018. Accessed June 19, 2019. https://www.nationalcoalitionhpc.org/wp-content/uploads/2020/07/NCHPC-NCPGuidelines_4thED_web_FINAL.pdf
23. Morrison RS, Meier DE. *America's Care of Serious Illness: 2015 State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals*. Center to Advance Palliative Care; 2015.
24. Ghashghaei R, Yousefzai R, Adler E. Palliative care in heart failure. *Prog Cardiovasc Dis*. 2016;58(4):455-460.
25. Lemond L, Allen LA. Palliative care and hospice in advanced heart failure. *Prog Cardiovasc Dis*. 2011;54(2):168-178.
26. Mebazaa A, Yilmaz MB, Levy P, et al. Recommendations on pre-hospital and early hospital management of acute heart failure: a consensus paper from the Heart Failure Association of the European Society of Cardiology, the European Society of Emergency Medicine and the Society of Academic Emergency Medicine—short version. *Eur Heart J*. 2015;36(30):1958-1966.

27. Cerlinskaite K, Javanainen T, Cinotti R, Mebazaa A; Global Research on Acute Conditions Team (GREAT) Network. Acute heart failure management. *Korean Circ J*. 2018;48(6):463-480.
28. Rasmussen K, Galvao M. Acute decompensated heart failure. In: Paul S, Kirkwood P, eds. *Heart Failure Nursing Certification: Core Curriculum*. 2nd ed. American Association of Heart Failure Nurses; 2015:169-201.
29. Jackson M. Palliative care referral in heart failure. *The Connection*. 2019; 59:10-11.
30. Blinderman CD, Homel P, Billings JA, Portenoy RK, Tennstedt SL. Symptom distress and quality of life in patients with advanced congestive heart failure. *J Pain Symptom Manage*. 2008;35(6):594-603.
31. Wilson J, McMillan S. Symptoms experienced by heart failure patients in hospice care. *J Hosp Palliat Nurs*. 2013;15(1):13-21.
32. Parshall MB, Schwartzstein RM, Adams L, et al. An official American Thoracic Society statement: update on the mechanisms, assessment, and management of dyspnea. *Am J Respir Crit Care Med*. 2012;185(4):435-452.
33. Goodlin SJ. Palliative care in congestive heart failure. *J Am Coll Cardiol*. 2009;54(5):386-396.
34. Murakami M. Opioids for relief of dyspnea immediately before death in patients with noncancer disease: a case series study. *Am J Palliat Care*. 2019;36(8):734-739.
35. Whellen DJ, Goodlin SJ, Dickinson MG, et al. End-of-life care in patients with heart failure. *J Card Fail*. 2014;20(2):121-132.
36. Qian Y, Wu Y, Rozman de Moraes A, et al. Fan therapy for the treatment of dyspnea in adults: a systematic review. *J Pain Symptom Manage*. 2019; 58(3):481-486.
37. Banzett RB, Schwartzstein RM, Lansing RW, O'Donnell CR. Aerosol furosemide for dyspnea: high-dose controlled delivery does not improve effectiveness. *Respir Physiol Neurobiol*. 2018;247:24-30.
38. Rutledge T, Reis VA, Linke SE, Greenberg BH, Mills PJ. Depression in heart failure: a meta-analytic review of prevalence, intervention effects, and associations with clinical outcomes. *J Am Coll Cardiol*. 2006;48(8): 1527-1537.
39. O'Connor CM, Jiang W, Kuchibhatla M, et al. Safety and efficacy of sertraline for depression in patients with heart failure: results of the SADHART-CHF (Sertraline Against Depression and Heart Disease in Chronic Heart Failure) trial. *J Am Coll Cardiol*. 2010;56(9):692-699.
40. Angermann CE, Gelbrich G, Störk S, et al. Effect of escitalopram on all-cause mortality and hospitalization in patients with heart failure and depression: the MOOD-HF randomized clinical trial. *JAMA*. 2016; 315(24):2683-2693.
41. He W, Zhou Y, Ma J, Wei B, Fu Y. Effects of antidepressants on death in patients with heart failure: a systematic review and meta-analysis. *Heart Fail Rev*. 2020;25(6):919-926.
42. Stewart D, McPherson ML. Symptom management challenges in heart failure: pharmacotherapy considerations. *Heart Fail Rev*. 2017;22(5):525-534.
43. Goodlin SJ, Wingate S, Albert NM, et al. Investigating pain in heart failure patients: the Pain Assessment, Incidence, and Nature in Heart Failure (PAIN-HF) study. *J Card Fail*. 2012;18(10):776-783.
44. Pantilat SZ, O'Riordan DL, Rathfon MA, Dracup KA, De Marco T. Etiology of pain and its association with quality of life among patients with heart failure. *J Palliat Med*. 2016;19(12):1254-1259.
45. Abdulla A, Adams N, Bone M, et al. Guidance on the management of pain in older people. *Age Ageing*. 2013;42(suppl 1):i1-i57.
46. Leemhuis A, Shichishima Y, Puntillo K. Palliation of thirst in intensive care unit patients: translating research to practice. *Crit Care Nurse*. 2019; 39(5):21-28.
47. Psotka MA, McKee KY, Liu AY, DeMarco T. Palliative care in heart failure: what triggers specialist consultation? *Prog Cardiovasc Dis*. 2017;60(2): 215-225.
48. Vest AR, Chan M, Deswal A, et al. Nutrition, obesity, and cachexia in patients with heart failure: a consensus statement from the Heart Failure Society of America Scientific Statements Committee. *J Card Fail*. 2019; 25(5):380-400.
49. Christensen HM, Kistorp C, Schou M, et al. Prevalence of cachexia in chronic heart failure and characteristics of body composition and metabolic status. *Endocrine*. 2013;43(3):626-634.
50. National Consensus Project for Quality Palliative Care Task Force. Clinical Practice Guidelines for Quality Palliative Care. 2013. Accessed March 22, 2021. <https://www.nationalconsensusproject.org>
51. Balboni TA, Paulk ME, Balboni MJ, et al. Provision of spiritual care to patients with advanced cancer: associations with medical care and quality of life near death. *J Clin Oncol*. 2010;28(3):445-452.
52. Monareng LV. An exploration of how spiritual nursing care is applied in clinical nursing practice. *Health SA Gesondheid*. 2013;18(1):a635. doi:10.4102/hsag.v18i1.635.
53. Warrich HJ, Rogers JG, Dunlay SM, Hummel E, Mentz RJ. Top ten tips for palliative care clinicians caring for heart failure patients. *J Palliat Med*. 2018;21(11):1646-1650.
54. Freeman B. CARES: an acronym organized tool for the care of the dying. *J Hosp Palliat Nurs*. 2013;15(3):47-153.
55. Dev S, Abernethy AP, Rogers JG, O'Connor CM. Preferences of people with advanced heart failure—a structured narrative literature review to inform decision making in the palliative care setting. *Am Heart J*. 2012;164(3): 313-319.e5. doi:10.1016/j.ahj.2012.05.023
56. Lampert R, Hayes DL, Annas GJ, et al. HRS expert consensus statement on the management of cardiovascular implantable electronic devices (CIEDs) in patients nearing end of life or requesting withdrawal of therapy. *Heart Rhythm*. 2010;7(7):1008-1026.
57. The SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients: the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT). *JAMA*. 1995;274(20):1591-1598.
58. American College of Cardiology. Quality Improvement for Institutions. Accessed April 11, 2019. https://cvquality.acc.org/login?url=http://cvquality.acc.org/clinical-toolkits/advance-care-planning-toolkit/index/?_ga=2.181772835.5460787.1529933437-932940414.1499630753&utm_medium=print_qr&utm_source=cardiology_mag&utm_campaign=cardiology_mag&utm_content=20180700
59. Dionne-Odom JN, Hooker SA, Bekelman DB, et al. Family caregiving for persons with heart failure at the intersection of heart failure and palliative care: a state-of-the-science review. *Heart Fail Rev*. 2017;22(5):543-557.
60. Hodson AR, Peacock S, Holtslander L. Family caregiving for persons with advanced heart failure: an integrative review. *Palliat Support Care*. 2019; 17(6):720-734.
61. Sidebottom AC, Jorgenson A, Richards H, Kirven J, Sillah A. Inpatient palliative care for patients with acute heart failure: outcomes from a randomized trial. *J Palliat Med*. 2015;18(2):134-142.
62. Widera E, Pantilat SZ. Hospitalization as an opportunity to integrate palliative care in heart failure management. *Curr Opin Support Palliat Care*. 2009;3(4):247-251.
63. Teuteberg J, Teuteberg W. Palliative care for patients with heart failure: expert analysis. 2016. Accessed May 1, 2019. <https://www.acc.org/latest-in-cardiology/articles/2016/02/11/08/02/palliative-care-for-patients-with-heart-failure>
64. Brännstrom M, Boman K. Effects of person-centered and integrated chronic heart failure and palliative home care: PREFER: a randomized controlled study. *Eur J Heart Fail*. 2014;16(10):1142-1151.
65. Wong FKY, Ng AYM, Lee PH, et al. Effects of a transitional palliative care model on patients with end-stage heart failure: a randomised controlled trial. *Heart*. 2016;102(14):1100-1108.
66. Gelfman LP, Barrón Y, Moore S, et al. Predictors of hospice enrollment for patients with advanced heart failure and effects on health care use. *JACC Heart Fail*. 2018;6(9):780-789.
67. Wolf AT, White KR, Epstein EG, Enfield KB. Palliative care and moral distress: an institutional survey of critical care nurses. *Crit Care Nurse*. 2019;39(5):38-49.