



North West London Cardiac Network

Symptom Control Guidelines for patients with Chronic Heart Failure

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Introduction

The management of heart failure has improved considerably in recent years but there still remain a significant number of people who will die from this chronic disease (around 40% of CHF sufferers will die within a year of diagnosis) and greatly benefit from palliative care.

The National Service Framework (NSF) for coronary heart disease has identified the need for palliative care, indicating the heavy burden of symptoms, a lack of communication and many psychological and social needs that are not being met. CHF impairs quality of life more than almost any other chronic medical problem.

Despite the improvements in management of CHF it remains a common, serious and increasing problem in terms of the need for palliative care. The many lessons that have been learned about palliative care for cancer patients need to be transposed to CHF patients. Talking to the patients, managing pain, nausea and distress and the many facets of good terminal care should be requisite to the heart failure palliative care pathway.

Palliative care has been defined by NICE (2004) as:

“.... the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments”.

It states that Palliative care aims to:

- Affirm life and regard dying as a normal process
- Provide relief from pain and other distressing symptoms
- Integrate the psychological and spiritual aspects of patient care
- Offer a support system to help patients live as actively as possible until death
- Offer a support system to help the family cope during the patient's illness and in their own bereavement

To be able to provide a seamless service for CHF patients on the palliation pathway it will be important to develop a more co-ordinated approach and establish good clear working relationships between cardiology services, care of the elderly, community heart failure services and specialist palliative care services.

These guidelines have been produced to provide healthcare professionals looking after patients with end-stage heart failure to focus on symptoms that are either particularly common or especially troublesome in this patient group. These guidelines should be used in conjunction with locally developed strategies and relevant documentation e.g. screening tools, referral criteria between services and assessment needs of patients and their carers.

Criteria for referral to Specialist Palliative Care of Heart Failure patients

(All at discretion of referrer & in conjunction with clinical assessment)

Patient and medical team (hospital or GP) aware of and agree to referral.

It is generally expected that referral to specialist palliative care will be in an indirect educative and supportive capacity for less complex patients and directly involved for more complex patients. Referral should only be considered when the needs of the patients cannot be adequately addressed or supported by the heart failure multidisciplinary team.

Regular MDT meetings are recommended to assist in identifying and addressing the needs of patients who may require further specialist care.

Plus 2 or more of the following:

1. NYHA (New York Heart Association) class 3 or 4 ♦Heart Failure
2. Uncontrolled physical symptoms despite optimal dosages of evidence based cardiac medications
3. 3 acute hospital admissions or episodes of decompensation within the past 12 months due to symptoms of heart failure
4. Complex psychosocial/spiritual needs

♦ New York Heart Association class 3 or 4 dyspnoea on minimal exertion or at rest

Symptom Control

Involvement from all members of the multidisciplinary team needs to be considered and sought as appropriate.

Symptom control should continue in conjunction with active cardiology management, including diuretics, ACE inhibitors, beta-blockers etc if providing symptomatic relief and patient's compliance is agreed.

Application of a holistic approach needs to apply, therefore considering patients and their carers/families physical, psychological, social and spiritual needs.

In the event of sudden deterioration of physical well being a reversible cause needs to be excluded, for e.g. infections, thyrotoxicosis, diabetic crisis, anaemia, arrhythmia, pulmonary embolism.

These guidelines are solely for use as symptom control guidelines for end-stage heart failure patients. They should be used in conjunction with locally agreed guidance and national NICE guidelines (2003) for recommended best practice.

1. Dry Mouth

Assess for underlying reversible causes, e.g. oral thrush, oxygen or nebuliser therapy or medication side effects.

Management:

- Ice cubes/ ice pops
- Boiled sweet e.g. acid drops
- Sugar free chewing gum
- Oral balance gel

If oral thrush consider:

- Nystatin 2mls qds or 1 lozenge qds
- Also consider Fluconazole 50mg od for 5 days or 150mg stat dose for severe doses

2. Cachexia and Anorexia

Assess for underlying reversible causes, e.g. dry mouth, oral thrush, nausea and vomiting, constipation, breathlessness, depression.

Patients with heart failure are prone to having poor appetites and lose significant amounts of weight.

Management:

- High calorie, high protein diets with no added salt
- Supplement drinks, soups and puddings
- High fat supplement, e.g. Calogen
- Highly spiced and flavoured foods
- Steroid use is generally contraindicated in heart failure patients as they can exacerbate the disease. But in very severe cases it maybe worth thinking about their role and discussing with the lead Clinician and/ or Specialist heart failure team

3. Nausea and Vomiting

Nausea is an unpleasant feeling of the need to vomit often accompanied by autonomic symptoms

Vomiting is the forceful expulsion of gastric contents through the mouth

Comprehensive assessment:

- Patient history and physical examination
- Consider reversible causes and exacerbating factors where ever possible e.g. constipation, infection, severe pain, cough, medications

Choose anti-emetic(s) according to their mode of action and the likely cause of nausea and/or vomiting:

See Table to show drugs used in the treatment of Nausea and Vomiting

- Prescribe the most appropriate anti-emetic regularly and “as required” (p.r.n.) (PRN antiemetic should be from a different class to the regular one)
- Prescribe via appropriate route of administration: use oral route for nausea prophylaxis, if absorption is in doubt consider subcutaneous (SC) or rectal (PR) route
- Consider non-drug measures e.g. anxiety management
- Reassess regularly, review anti-emetic dose every 24 hours.
- If not controlled despite these measures consider referral to specialist palliative care for advice.

4. Table to Show Drugs used in the Treatment of Nausea and Vomiting

Treat underlying cause if possible. Choice of anti-emetic depends on cause and site of drug action. Use oral route for nausea prophylaxis, consider subcutaneous or rectal route if vomiting. A combination of drugs may be needed.

Drug	Action	Site	Use	Dose
METOCLOPRAMIDE	Dopamine (D2), 5HT3, 5HT4 antagonist Potent prokinetic	GI tract	Gastric stasis First Line	PO/ SC* 10-20mg QDS CSCI* 30-100mg/24 hours
DOMPERIDONE	Dopamine (D2) antagonist Weak prokinetic	GI tract	Gastric stasis First Line	PO 10-20mg QDS PR 30-60mg QDS
HALOPERIDOL	Dopamine (D2) antagonist	Chemoreceptor trigger zone	Opioid induced nausea and vomiting, uraemia First line	PO 1.5-5mg NOCTE or PRN SC/ CSCI* 2.5-10mg/24 hours
LEVOMEPRMAZINE	Dopamine, histamine 1, acetylcholine, 5HT2, alpha-adrenergic antagonist Broad spectrum	Vomiting centre	Unknown cause Care of the dying Second line	PO/ SC 6.25-12.5mg NOCTE CSCI 6.25-25mg/24 hours
GRANISETRON OR	5HT3 antagonist	GI tract	Bowel distension, uraemia Third line	PO/SC* 4-8mg BD?? CSCI* 8-16mg/24 hours??
ONDANSETRON	5HT3 antagonist	GI tract	Bowel distension, uraemia Third line	PO/SC* 4-8mg BD CSCI* 8-4mg/24 hours

*Unlicensed use or route but accepted practice in Palliative Care, CSCI: continuous subcutaneous infusion (via syringe driver)
Do not use Cyclizine as this can worsen Heart Failure, can lead to worsening fluid retention.

5. Constipation

Is characterised by infrequent and difficult defecation of small and hard faeces

Assessment:

- Normal frequency of defecation
- Current frequency of defecation
- Consistency of stool
- Ease of defecation
- Size and volume of stool

Contributing causes:

- Drugs (e.g. opioids / antiemetics, diuretics)
- Immobility
- Poor diet
- Depression
- Dehydration

Management:

- Treat underlying cause where appropriate / possible
- Encourage good fluid intake, dietary intake and increased mobility
- Understand patient's individual normal bowel pattern
- Daily assessment of constipation
- Prescribe oral laxatives
- Titrate doses of laxatives according to response
- Discuss management plan and options with patient in a safe and comfortable environment

Drug management:

- Senna (to stimulate the bowel) 7.5 mg tablet twice daily (oral syrup 7.5mg/5ml) maximum: 15mg twice a day
- **and** Docusate sodium (mainly softens the faeces but does provide also a mild stimulant to the bowel) 100mg capsule twice daily (oral solution 50mg/5ml) titrate up by 100mg as required, maximum: 600mg daily

6. Breathlessness

Consider possible reversible causes other than heart failure e.g. medication side effects (β - blockers) and psychological causes (anxiety)

Non-pharmacological management:

- Breathing retraining
- Relaxation
- Complementary therapies
- Hypnotherapy
- Anxiety management and education
- Occupational therapy for lifestyle adjustments

Pharmacological Management:

- GTN spray 1- 2 puffs prn, repeated in 5 minute intervals, maximum TDS
- Nebulised bronchodilators eg salbutamol 2.5mg or terbutaline 2.5mg prn to qds
- if co- existing angina, ensure GTN spray available as bronchodilators may precipitate angina
- Bronchodilators not effective if patient is also taking β - blockers
- Consider monitoring potassium every 4 weeks, if appropriate
- Lorazepam 0.5 – 1mg sublingually prn to max 4mg daily- especially effective if there is an element of anxiety. Diazepam 2mg po can be considered as a second-line agent.]
- Oramorph 2mg prn to assess the effect, up to a maximum of 4 hourly. Dose can be increased as needed
- Morphine is renally excreted and should be used in extreme caution with patients with impairment. Administration may need to be 'prn' in the first instance.
- Oxygen therapy can be tried for patients that are hypoxic, but it can also be considered for its psychological benefit.

7. Cough

In patients who have been on ACE inhibitors long-term it is unlikely that this will be the cause of a cough, so they should not be automatically stopped. If however they have been recently commenced on them they must be considered as the possible cause and reviewed.

Cough suppressants:

- Simple linctus 5 – 10mls prn to qds
- Codeine linctus 5 – 10mls prn to qds
- Oramorph 2mg prn

If related to difficulty expectorating:

- Normal saline nebulas 2.5mls prn

8. Pain

A high proportion of heart failure patients experience pain. Pain can be non-specific, generalised and difficult to explain.

Pain needs to be fully assessed, this includes the site, intensity, pattern, possible cause, aggravating factors, relieving factors and methods already used to try and alleviate. The pain may not be due to heart failure, but another pathology or unrelated cause.

The importance of a multi professional approach cannot be stressed enough. All members of the team need to be involved in order to consider the psychological, social, physical and spiritual aspects of the pain.

Pain has many different meanings and connotations to patients that need to be explored.

- Anti- angina medications need to be considered if cardiac pain
- Non- steroidal anti- inflammatory medications can worsen renal failure and consequently heart failure. They should therefore **NOT** be used in patients with heart failure unless agreed by lead clinician and/ or specialist heart failure team
- See: **Guidelines for the relief of pain in adults with heart failure**

9. Guidelines for the relief of pain in adults with heart failure

Assess **“TOTAL”** PAIN frequently and regularly
Acknowledge psychosocial and spiritual components of pain

STEP 1: Mild Pain

PARACETAMOL 1g 4- 6 hourly
Maximum 4g in 24 hours

STEP 2: Moderate Pain

WEAK OPIOID +/-PARACETAMOL

e.g. codeine 15-30mg, 6 hourly *or*
dihydrocodeine 15-30mg, 6 hourly Maximum 4 times daily
(Can be given as a compound preparation of weak
opioid/paracetamol e.g. co-codamol 15/500, 2 tablets
maximum 4 times daily) *or* Tramadol 50-100mg qds

Prescribe **regular laxatives** when
opioids taken regularly
(see step 3)

STEP 3: Severe Pain

STRONG OPIOID +/-PARACETAMOL

Start **immediate release oral morphine**
e.g. Oromorph or Sevredol 2-10mg, 4 hourly *and*
“as required” (p.r.n.), dose equivalent to 4 hourly
for **breakthrough pain**

Stop step 2 weak opioid

N.B. Consider a **reduced dose** in elderly or
those with renal impairment e.g. Oromorph 1mg 8 -12 hourly

Prescribe regular laxatives
senna + docusate sodium

Prescribe prophylactic antiemetic
“as required” (p.r.n.) for 3-5 days
e.g. haloperidol 1.5mg – 3mg nocte

PAIN NOT CONTROLLED

PAIN CONTROLLED

Encourage use of p.r.n. breakthrough
immediate release morphine

If 3 or more breakthrough doses
required in 24 hours increase 4 hourly
morphine dose by 30–50% until pain is controlled

N.B. Remember to increase breakthrough
(p.r.n.) dose, equivalent to 4 hourly

Convert to equivalent dose of modified
release morphine
e.g. MST Continus, 12 hourly:

- calculate total 24 hour dose immediate
release morphine and divide by 2
- prescribe p.r.n. dose of immediate
release morphine at 1/6th of 24 hour
total dose, for breakthrough pain

If increased dose of morphine
does not help – review diagnosis,
use of adjuvant analgesics and
other treatments.

Monitor for signs of opioid toxicity:

- Increased drowsiness
- Hallucinations
- Muscle twitching/ myoclonus

If toxicity occurs, reduce opioid dose by 1/3 **or** stop
and convert to weak opioid; ensure patient is well
hydrated.
Consider adjuvant therapies and /or alternative opioids
– seek **specialist palliative care advice**

10. Peripheral Oedema

Mainly occurs in the lower limbs, but may also extend to the genitalia, abdomen and upper limbs. It can cause patients great distress, discomfort and pain. It also can alter their body image and perception of themselves, therefore affecting them not only physically, but in all aspects of their life.

Non-pharmacological management:

- OT and Social Service assessment to look at adapting and adjusting home environment and patient and carers expectations of their abilities
- Primary care assessment from District Nurse and if appropriate Tissue Viability Nurse
- Advice for patient on life style changes needed e.g. leg elevation, rest periods
- Legs need to be kept moist to prevent skin breakdown. Educating patients and carers is imperative. Use of liberal amounts of aqueous cream should be recommended. If the skin is itchy aqueous cream and 0.5% Menthol can ease sensation
- Bandaging and scrotal supports can be of some benefit, but patients often find them uncomfortable and restrictive

Pharmacological management:

- Diuretics
- Furosemide can be up titrated by 40mg bd to a maximum dose of 80mg bd, changing to Torasemide 5mg od, increasing to a maximum of 20-40mg a day for recurrent fluid retention Or Bumetanide 1mg bd to a maximum of 2mg bd
- Spironolactone can also be added
- If renal function and BP allows Metolazone 2.5mg stat can be given as a one off dose or every other day

11. Psychological Issues

Psychological issues occur for many differing reasons with heart failure patients. Causes can be the diagnosis of heart failure itself and coming to terms with that, or the life changes and immobility that can come with their diagnosis and the changes in body image and sexual function.

It is important to explore with patients the underlying causes of their feelings and fears. In order to do this effectively all members of the multidisciplinary team need to be included.

Patients can present with many differing issues, such as:

- Fatigue
- Insomnia
- Low motivation
- Anxiety
- Low mood
- Depression
- Anger

Depression is common in heart failure patients and it is worth considering screening them routinely for this. This can be done using established scales or more informally by asking some trigger questions.

For example:

- Do you think you are depressed?
- What do you think your mood has been like for the past two weeks?
- How do you feel when you wake up in the morning?
- How are you sleeping?
- Do you look forward to anything in your life at the present time?

Non- pharmacological treatments should be considered in all patients. It is worth considering:

- Relaxation classes
- Counselling
- Complementary therapies
- Hypnotherapy
- Sleep hygiene
- Spiritual care
- Cognitive behavioural therapy

Pharmacological management also needs to be considered in many cases. Drugs that can be safely used:

Insomnia

- Zopiclone 7.5 – 15mg po nocte
- Temazepam 10 – 20mg po nocte

Anxiety and panic

- Lorazepam 0.5 – 1mg s/l prn (max tds)
- Diazepam 2mg po (max tds)

Depression

- Sertraline 50mg po od
- Citalopram 10 – 20mg po od, if anxiety related

Do not use Tricyclic antidepressants as contraindicated in Heart Failure and can lead to worsening fluid retention.

12. Financial Issues

Patients suffering from Heart Failure maybe entitled to some financial support. There are three main benefits currently in the UK. These are the Incapacity Benefit, Disability Living Allowance and the Attendance Allowance.

Incapacity Benefit (IB)

You are eligible to claim if your statutory sick pay has ended, or if you are self-employed or unemployed. To be able to claim it you must be unable to work because of illness or disability. It is paid in three weekly rates depending on how long you've been unable to work for.

Disability Living Allowance (DLA)

This benefit is for people who are aged 65 or under. It is tax-free and non-means tested. You are entitled to it if you need help getting around and/ or looking after yourself because you are ill, disabled or terminally ill.

Attendance Allowance (AA)

This benefit is for people aged 65 and over. It is tax-free and non-means tested. You are entitled to claim it if you have an illness or disability and need help with personal care

Patients are usually entitled to the DLA and AA if they have needed help for at least the last 6 months.

Special Rules

If a patient has an expected prognosis of 6 months or less (NYHA 4) you can claim for them under the 'Special rules'. If their prognosis is less than 6 months they do not have to have needed care for the past 6 months. You can complete a form called the DS1500 and send this with their DLA or AA form as normal. The process is then much quicker and the benefits are usually received within 2 -3 weeks of the form being received.

Free Prescriptions

Patients under 65 are eligible for free prescriptions if they cannot get out of their home without the aid of another person. A form called 'Prescription Exemption' can be completed and an exemption card will be sent directly to them. Ask at a local pharmacy for a form.

Disabled Parking badges

The 'Blue Badge' scheme provides patients with parking benefits within the UK and Europe. Patients are entitled to it if they are receiving the higher rate of the mobility component of the DLA or receiving War Pensioner's Mobility supplement, or if they have substantial disability, which causes inability to walk, or very considerable difficulty in walking.

Carers Allowance

This is a benefit for a person who care's for someone who is disabled. They do not have to be related, or live with the person they care for in order to qualify. They are entitled to claim if they are aged 16 and over and spend at least 35 hours a week caring for the person getting the DLA or AA. The DLA must have been awarded at the middle or higher rate for personal care in order to qualify

Travelling Abroad

This must only be done with full medical insurance in patients with Heart Failure. Many insurance companies will however exclude this group of patients or quote extremely high premiums. Patients need to be reminded to take their EHIC cards. The old E111 forms are no longer valid in Europe.

A list of insurance companies that will consider Heart Failure patients can be found on the British Heart Foundation website: www.bhf.org.uk

The BACUP website also list companies that will consider people with terminal illnesses: www.cancerbacup.org.uk or by calling them on 0808 800 1234.

13. The terminal stages of Heart Failure

Good, effective communication with patients and their families is imperative and never more so than when someone's condition is beginning to deteriorate.

Patients, families and carers need to be made fully aware of what is happening and what is likely to happen to the patient over the next few weeks and days. Some may not be aware or understand the terminal nature of the disease as it progresses. Time needs to be set aside in order to give them the space to explore this with you.

As a patient's condition begins to deteriorate and their prognosis shortens into weeks/days it may be sensible to look at their current drug regimens so that they only have to take the minimum amount. It may be worth considering stopping non-essential drugs such as:

Aspirin	Clopidogrel
Warfarin	Ferrous Sulphate
Calcichew	Allopurinol
Potassium preparations	Statin agents
Spirolactone	Beta-blockers
Thiamin and other Vitamin B preparations	

All medications should be considered and their benefit to the patient's comfort considered as the main objective.

The last few days of life

The majority of patients' conditions will deteriorate slowly and over a period of weeks and days, but it is also important to consider the risk of a sudden death occurring.

For those patients that deteriorate more slowly it is imperative that patients and all members of the multidisciplinary team have agreed that there is no reversible cause and that the patient is no longer for active, interventional treatments.

Implantable Cardioverter Defibrillators (ICD's)

ICD's are slightly bigger than traditional pacemakers and work quite differently to them. They monitor cardiac output and rhythm and then deliver shocks to the heart when dangerous changes to these occur, for example, ventricular tachycardia and ventricular fibrillation. More and more patients are now being offered and fitted with ICD devices.

As a patient's condition deteriorates discussions with them and their carer about how the device is managed as they are dying is required. It may be necessary to have the device re-explained to them and what will happen should the device not be deactivated. It needs to be explained that the

deactivation of the device is totally painless and usually unlikely to result in immediate death. Many patients may not wish to remain for cardio-pulmonary resuscitation. The patient may wish for the device to be deactivated.

If it is not deactivated in advance, the patient can receive unpleasant electric shocks as they are dying. These shocks can continue for over an hour after death, until the battery capacity of the device is exhausted. With many ICD's, placing a strong magnet on the skin over the ICD will prevent it delivering any shocks. If this is unavailable or ineffective, discomfort can be minimised by administering Midazolam and/or morphine intravenously.

Who actually carries this out is down to local policy but your specialist centre will have an established protocol of what to do and who to contact, it needs to be recognised though that many centres may only be able to do this within working hours.

All ICD's can, even when deactivated, retain their pacing function. Decisions about the deactivation of an ICD in a patient need to be reviewed regularly and should the patient's condition improve, re-activation of the ICD may be indicated. Discussions need to be had as early on as possible to avoid last minute decisions having to be made.

The Liverpool Care Pathway (LCP) for the Dying Patient

LCP has been developed for the management of patients with cancer. The aim of the guidelines are to enable health care professionals to give the best and most appropriate care to patients and their families, and therefore ensuring a peaceful and dignified death (Ellershaw & Wilkinson, 2003).

The LCP is now being rolled out to non-cancer areas including patients with CHF. See local guidelines for current policy on management of the dying patients or contact your local Specialist Palliative Care Team for advice.

Diagnosing dying

The dying process can be very difficult to diagnose and is even more so in patients with Heart Failure. The LCP has been developed to aid this process. It is suggested that if two of the following four conditions apply, a patient is dying:

- Bed-bound
- Semi-comatose
- Only able to take sips of fluid
- No longer able to swallow medication

Medications need to be further rationalised and all non-relevant medications stopped. Inappropriate nursing and medical interventions also need to be reviewed and in many cases stopped. All interventions should be considered and only performed if adding to patients' comfort.

At this stage, medications that maintain patients' comfort and control of their symptoms are the only essential ones to continue. The route medications can be administered also needs to be established. Medications will need to be prescribed by the subcutaneous route; ensuring prn medications for the commonest symptoms are available.

The commonest symptoms that dying patients will experience are:

- Pain
- Nausea and vomiting
- Terminal restlessness and Agitation
- Breathlessness or increased respiratory secretions.

Suggestions for the management of these symptoms in dying heart failure patients on page 25, but local LCP guidelines exist in most clinical areas.

The Gold Standards Framework (GSF)

The GSF programme offers primary health care teams a widely used framework of enabling tools and resources to help optimise their palliative care, so that they can fulfil the wishes of both patient and carers. It aims to improve management of symptoms, reduce the elements of fear and uncertainty, enables patients to attain their preference for place of care and improves support for carers.

The GSF aims to clarify triggers for consideration of patients in need of supportive/palliative care with the main processes used to identify, assess, plan, and at all times communicate about patient care and preferences.

Once patients are identified as being in need of supportive/palliative care, further assessments and plans of care can be made eg holistic needs assessment, Advance Care Plans (eg preferred place of care), and the appropriate management care plan.

Suggested Criteria for inclusion on Specialist Care Register:

1. Need for supportive/palliative care
2. The 'Surprise' question: Would you be surprised if the patient were to die in the next 6-12 months. Attendance allowance DS1500
3. Clinical indicators NYHA Stage 3 or 4

Further information for implementing the GSF is available from your local PCT GSF Facilitator and www.goldstandardsframework.nhs.uk

Pain

Diamorphine 2.5mg or Morphine 2.5mg sc 4 hourly for opiate naive patients.
Doses may need to be titrated according to response.

Advice needs to be sought from the specialist palliative care team if patients are already on a step 3 analgesia.

If patients require frequent injections for pain a syringe driver should be considered for more effective control, again consult specialist palliative care team for advice.

If patients are in severe renal failure please consult specialist palliative care team before suggesting any analgesia.

Nausea and vomiting

Levomepromazine 6.25mg sc 6 hourly

If patients require frequent injections a syringe driver should be considered for more effective control, again consult specialist palliative care team for advice.

Terminal restlessness and agitation

Midazolam 2.5 – 5mg sc prn

Doses may need to be titrated according to response.

If patients require frequent injections a syringe driver should be considered for more effective control, again consult specialist palliative care team for advice.

Breathlessness or increased respiratory secretions

Glycopyrronium 0.2mcg sc prn

If patients require frequent injections a syringe driver should be considered for more effective control, again consult specialist palliative care team for advice.

For patients who have a lot of fluid and oedema it maybe worth considering continuing their diuretics and converting them to the sc route.

Furosemide 10-20mg sc prn.

Bumetanide 1mg sc prn.

If effective and patients require frequent injections a syringe driver should be considered for more effective control, again consult specialist palliative care team for advice.

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