

Palliative care: Essential support for patients with heart failure in the COVID-19 pandemic

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Keywords

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Introduction

In March 2020, the World Health Organisation declared COVID-19 as a global pandemic. Patients with cardiovascular conditions, including heart failure (HF), are disproportionately impacted by this new disease. Escalating mortality figures and pressures on staff and resources have challenged us on how best to support those affected, and how to deal with death and dying. This short paper will review health practice and policy changes arising from this coronavirus pandemic and signpost a selection of available tools and resources that can assist healthcare professionals in providing optimal palliative and end of life care for HF patients in the current and post COVID-19 eras.

As shielding and social distancing of varying degrees was instigated across most European countries, the provision of conventional models of HF service delivery was either suspended, or reconstituted in a virtual format through telephone consultations or the use of telemedicine.¹⁻³ Clinical trial evidence confirms that the integration of telehealth bolsters HF practice,⁴⁻⁶ but today's service providers noted requests for information from many patient-carer dyads on 'keeping well' and 'who to contact' if HF symptoms deteriorated. Services also reported the worrying observation of a reduced number of patients across the spectrum of cardiovascular disease attending hospital Emergency Departments. The effect of this trend may become evident later, in an increase in all-cause mortality as further data emerge. Recent position statements released both nationally and internationally have reiterated the importance of maintaining HF specialist services to facilitate prompt healthcare access for patients at points of crisis,^{3,7,8} requiring professionals to adopt variants of a previously accepted HF service structure.⁹ As the pandemic subsides and HF services are

reconfigured, some effective elements of the new virtual care models could be incorporated, avoiding some of the risks inherent in care transitions, and consolidating a more seamless continuum between hospital-based clinics and primary care.

Communication, supportive and palliative care

During this pandemic, good communication is essential. This is often nuanced and given the current requirement for personal protective equipment (PPE), hospitalized patients can no longer read professionals' body language in their smile or facial expression and are denied the solace of an un-gloved empathetic touch. To facilitate a more person-centred approach, it is important that the treating nurse or physician identifies themselves to their patients by name, providing verbal encouragement and reassurance as appropriate. This is especially important in the face of clinical deterioration, and in the United States, the Center to Advance

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Palliative Care has developed a COVID-19 response toolkit, cataloguing clinical resources for professionals regarding communication, symptom management, and Medicare emergency waivers, to facilitate early access to palliative care.¹⁰

The need to acknowledge the prognostic ambiguity intrinsic to HF, particularly in the COVID-19 context, and to undertake difficult conversations about end of life preferences, requires all relevant professionals to adopt a palliative approach, combining objectivity with compassion and truthfulness.¹¹ Emotional and sociocultural barriers may have to be navigated to facilitate valid shared decision making about future interventions.¹² Discussions regarding ceilings of care or withdrawal of treatment should take into account the HF patients' current physiological status and pre-existing quality of life, any formally enacted advance directives or statements, and their personal wishes and values, including an exploration of their cultural norms and spiritual beliefs.^{13,14} Unfortunately, as a consequence of the inordinate surge in demand for intensive care unit (ICU) beds for those requiring invasive ventilation, at times professionals have been compelled to make decisions on ICU access in the moment, based predominantly on the ethical concept of distributive justice, prioritizing allocation of this constrained resource to those considered most likely to survive.^{15,16}

An arbitrary assumption that HF patients exhibit a higher mortality risk, irrespective of their status on the disease trajectory, which renders them ineligible for this support, should be avoided. However, objective differences between patients under consideration for the same ICU bed space can be marginal, and such demanding judgement calls may be a source of moral distress to clinicians, resulting in burnout and fatigue.¹⁷ Furthermore, many healthcare professionals now caring for COVID-19 patients have been redeployed from their customary clinical environments, including those normally assigned to HF care, and are working outside their usual area of expertise in order to support heavily burdened clinical services. Some staff may feel conflicted, aware that their reassignment to support the obvious needs of COVID-19 patients might undermine the care of those for whom they are normally responsible. It is important to ensure systems of professional support are in place, with adequate processes for debriefing and reflective practice, to foster resilience.

Alleviation of distressing symptoms

Recent editorials provide clinical guidance addressing the supportive care of patients with COVID-19, and management of the palliative care needs of polysymptomatic HF patients have been recently updated.^{9,18} Common symptoms associated with COVID-19 are

fever, cough, breathlessness and muscle aches. Breathlessness tends to become the dominant symptom, this viral lung infection resulting in reduced pulmonary diffusion capacity leading to profound hypoxia and driving the need for high flow oxygen therapy. Surprisingly, in this perplexing disease, other patients exhibit 'silent hypoxia', experiencing minimal shortness of breath despite marked hypoxaemia. In addition to respiratory failure, the experience of breathlessness is also mediated by the degree of ventricular dysfunction, and is further influenced by psychological, environmental and sociocultural factors. Optimal management requires a multidisciplinary holistic approach. Pharmacological therapies such as the use of morphine remain appropriate,^{19,20} but, given the risk of viral dispersal, caution is advised in the use of some previously advocated non-pharmaceutical interventions such as fan therapy. Chest discomfort may accompany breathlessness, warranting prompt investigation if the patient exhibits evidence of acute ischaemia or has a known history of coronary artery disease.²¹

Resuscitation protocols and implanted devices

European Society of Cardiology guidance has provided updated information for both patients and professionals on how to prevent the spread and reduce the risk from COVID-19.⁸ This pandemic has prompted changes in cardiopulmonary resuscitation (CPR) guidelines whereby, for safety reasons, CPR should not be initiated by first responding patient-facing healthcare workers who should now wait until the arrest team arrives in full PPE, although defibrillation of a shockable rhythm can be undertaken without delay.^{22,23} The rationale for this ruling is that chest compressions may produce locally high levels of aerosol-generated viral contamination from COVID-19 patients, posing an increased risk of transmission to staff. Alongside this CPR protocol change, there has also been an increase in the number of do-not-resuscitate orders, often based on the patient's age, their comorbidity burden and perceived quality of life. For HF patients with an active implantable cardioverter-defibrillator (ICD) in situ, the significant COVID-19 related hypoxia or myocardial injury directly linked to the SARS-COV-2 virus may trigger arrhythmias and distressing shocks. Where relevant, and determined by patients' preferences, it is important that professionals discuss ICD deactivation to ensure device therapy remains consistent with any change in resuscitation policy.²⁴

Facilitating family involvement during clinical isolation

To avoid the risk of contagion, even close family members are now rarely permitted to breach the *cordon sanitaire* isolating areas where confirmed or suspected COVID-19 patients are being treated. Across hospital care settings, including ICUs, many professionals have described how they now often assume a surrogate role on behalf of the family in supporting the patient. However, real family involvement can be facilitated remotely with the use of smartphones and tablets to better ensure patients do not feel so isolated. Ideally, such methods of communication should be handled by a designated interlocutor acting on behalf of the clinical team, and prospectively scheduled updates provided to the family, at least on a daily basis.²⁵ Information on local arrangements for such family communication could be disseminated by means of hardcopy leaflets or email.¹⁸ Family involvement in contributing to the care process, by any means possible, may prevent unnecessary future distress should the patient's condition suddenly deteriorate, or if intensification of clinical intervention is deemed inappropriate. Some health professionals feel uncomfortable conversing indirectly in this way, concerned that telephone calls may not be the most appropriate means of communicating such complex clinical scenarios. In cases where the patient is unable to contribute by virtue of intubation or through delirium, fever or exhaustion, it is important the family or a legal guardian is consulted regarding next steps. Some platforms such as VitalTalk® (Seattle WA, USA), a not-for-profit organisation (www.vitaltalk.org), offer a suite of communication tools and training to aid professionals conduct difficult yet essential conversations with patients and family members.^{25,26}

Complicated grief

The harshest element demanded of the clinical isolation of people with COVID-19 is that their loved ones are unable to be with them as they die. This situation flies in the face of the normative perception of a good death, enabling the family to comfort their relative and say their 'goodbyes'. While attending staff can sit with patients to ensure they do not die alone, this will provide little consolation to grieving families. Similarly, relatives and community or faith leaders, are denied access to undertake the practices and rituals required of some cultures and religions around the time of death, and the form of funeral ceremonies may be truncated, with only a limited number of mourners permitted to attend. We have all baulked at images of multiple coffins lying in temporary mortuaries, or decedents' bodies being carried through cemeteries by

people unknown to them wearing PPE. Those trying to come to terms with the untimely loss of a family member or close friend in these circumstances are likely to be adversely affected for a prolonged period and may exhibit persistent complex bereavement. Palliative care can support such individuals, and, as noted in the Compassion in Dying website, it is important to create new expressions of humanity to prevent potential adverse effects on mental health and wellbeing associated with these difficult COVID-19 related deaths.²⁷

This short paper highlights just some of the evolving care components required in the clinical environment arising from the ongoing COVID-19 pandemic to fulfil the ethical imperative of providing palliative support for HF patients, often subject to significant existential distress. Clinical protocols have had to flex to address this challenging global emergency, and perhaps some of the lessons learned, including renewed attention to the integration of a palliative approach, will ultimately drive positive outcomes in societal attitudes as well as medical and nursing practice and research.

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