Improving Referral of Patients with Heart Failure to Palliative Care Services and Completion of ReSPECT Forms

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1 Background & Aim

- Advanced heart failure (HF) is associated with high symptom burden, including dyspnoea, fatigue, and reduced quality of life.
- Early palliative care involvement may improve symptom control, support advance care planning, and reduce burdensome end-of-life interventions.
- This quality improvement project aimed to improve identification of patients with HF who may benefit from palliative care referral and to increase timely discussion and completion of ReSPECT forms.

2 Methods & Baseline Measurement

- Retrospective review of patients aged >16 years identified from HF nursing team referral lists.
- Included inpatients (July–August 2025) and outpatients under ongoing HF follow-up.
- Notes were reviewed against a locally developed trigger tool derived from current guidance.
- Baseline cohort: 81 patients (43 inpatients, 38 outpatients).
- Sixteen patients met referral criteria; 6/16 were referred (37.5%).
- Among eligible patients, referral rates were 42% for inpatients (5/12) and 25% for outpatients (1/4).
- ReSPECT completion appeared low at baseline, although it was not formally quantified.

HF Palliative Care Referral Trigger Criteria

1. PROGNOSTIC FLAGS *(tick any if any of the below apply)*
- NYHA Class IIIB/IV (SOBOE at rest, minimal exertion)
- ≥ 2 HF admissions in 6 months or ≥ 1 admission + age ≥75

2. SYMPTOM BURDEN *(tick any if any of the below apply)*
- Refractory symptoms (dyspnoea, pain/fatigue despite optimal therapy)
- Requires specialist management for refractory symptoms

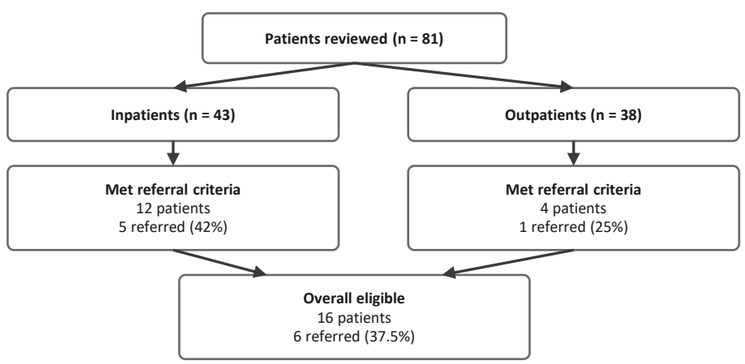
3. "NEED HELP" MARKERS *(tick yes if ≥ 2 present)*
- NYHA IIIB/IV (or eGFR<15)
- End-organ dysfunction (Cr >2.0, bilirubin >20)
- EF <35%
- Defibrillator shock (past 6 months)
- Hospitalised >1x (past year)
- Oedema despite maximal diuretics
- Low BP (<90 systolic) or HR >100
- Progressive medication intolerance

4. PATIENT/FAMILY NEEDS *(tick yes if the below applies)*
- Family/carer distress (e.g., coping, complex home care)

5. IF >70 YEARS AND/OR INELIGIBLE FOR ADVANCED HF THERAPIES, THEN CONSIDER REFERRAL TO PALLIATIVE CARE

6. "WOULD YOU BE SURPRISED IF THIS PATIENT DIED IN 12 MONTHS?" IF NO, CONSIDER ACP DISCUSSION/ ReSPECT FORM

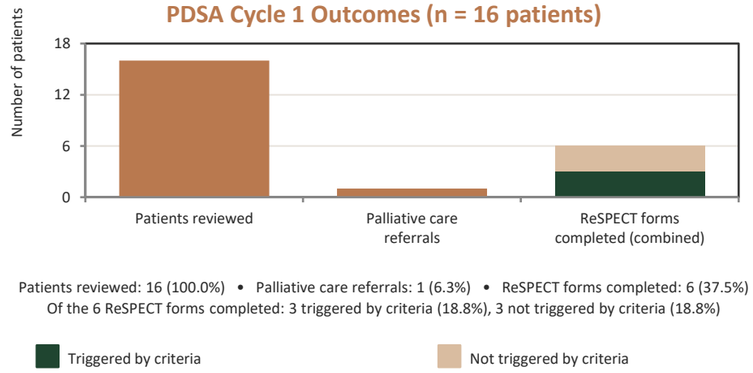
Baseline Cohort Flow



3 PDSA Cycle 1

- The trigger criteria were introduced as an auto-text and circulated to cardiology resident doctors for use in CCU and Whiteley Ward admissions with HF.
- The inpatient setting was prioritised to support multidisciplinary discussion regarding ceilings of care, palliative care referral, and ReSPECT documentation.
- Data were collected for 16 patients (9 Whiteley Ward, 7 CCU) between December 2025 and January 2026.
- Two patients were referred to palliative care; one referral pre-dated use of the tool.
- Six patients had ReSPECT forms completed during the admission; three of these were newly triggered by the criteria (18.8%).
- No patients were identified as clearly meeting referral criteria without some referral during this cycle.

PDSA Cycle 1 Outcomes (n = 16 patients)



4 PDSA Cycle 2 / Sustainability

- We collected data from 5 patients (limited number due to reduced team members being available to collect data) between the end of February and the end of March.
- None of the patients were referred to Palliative Care services.
- Two patients were eligible for referral to Palliative Care when the criteria were completed.
- In both cases, the form had been completed slightly incorrectly. This affected the final criteria outcome for one patient who was eligible for Palliative Care input but was not referred; however, this patient was responding to treatment.



4 PDSA Cycle 2 / Sustainability

- The second patient was transferred to Castle and was later discharged and subsequently died in the community. This patient was eligible for CRT.
- Of the 5 patients, 1 patient had a ReSPECT form updated, but this was completed prior to the criteria being used.

5 Conclusions

- A substantial proportion of patients with HF met criteria for palliative care referral, but many had not been referred at baseline.
- A simple trigger tool supported recognition of appropriate patients and appeared to prompt additional ReSPECT discussions.
- Short-term impact on referral numbers was modest, but the intervention was feasible, low cost, and easy to implement.
- Education and visible prompts are likely to be important for sustainability.

6 Key Learning Points

- Patients with HF often have unmet palliative care needs.
- Structured criteria can support, but not replace, clinical judgement.
- The intervention had greater immediate effect on advance care planning than on referral numbers.
- Small sample size and short follow-up limit interpretation.
- Future cycles should include outpatient implementation and formal measurement of ReSPECT completion.

Better identification, timely referral and advance care planning can improve quality of care for patients with heart failure.