SharedCare
Partners for Patients

SUPPORTIVE CARDIOLOGY TOOL

An interactive guide for patients with advanced heart failure

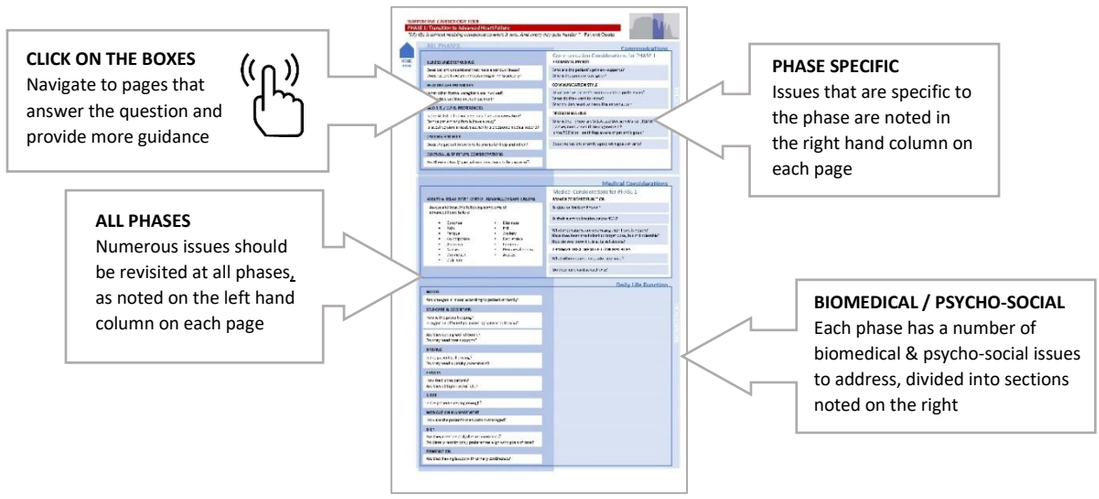
I. ABOUT THIS TOOL

This tool was designed for clinicians who have patients with advanced heart failure. This tool has been designed to support the patient's heart function and symptom control through to end of life. This tool has been created and is optimized for use on a computer, but can be used with most tablets.

It is divided into **3 phases of advanced heart failure:**

1) **TRANSITION TO ADVANCED HEART FAILURE** *(Marked by hospitalization for heart failure or refractory symptoms despite evidence-based treatment)*
2) **PERIODIC ASSESSMENT and/or EXACERBATIONS**
3) **END OF LIFE**

Feedback about this document, which will be reviewed periodically, can be sent to Palliative@islandhealth.ca



II. PATIENT SUPPORT MATERIALS

- Provide your patient with the partner document to ensure optimal care:
  What Really Matters Now: Notes for Living with Advanced Heart Failure ✉
- Optional questionnaire to have your patient complete in the waiting room prior to their visit.
  Heart Failure Patient Questionnaire ✉

III. TYPICAL COURSE of HEART FAILURE PATIENT

STAGES IN PATIENT ILLNESS *(numbered in graph)*

1. Initial symptoms and diagnosis of heart failure. Treatment begins.
2. Heart failure is stable. Treatments work well and symptoms are controlled.
3. Return of heart failure symptoms despite treatment- called a decompensation. Treatment is increased and symptoms improve. Over time, even with increased treatments, you do not return to the same level of health.
4. Return of heart failure symptoms, even though disease-modifying treatment at maximum. Since heart function cannot be improved, the focus of care turns to managing symptoms.
5. Approaching final weeks/months of life.

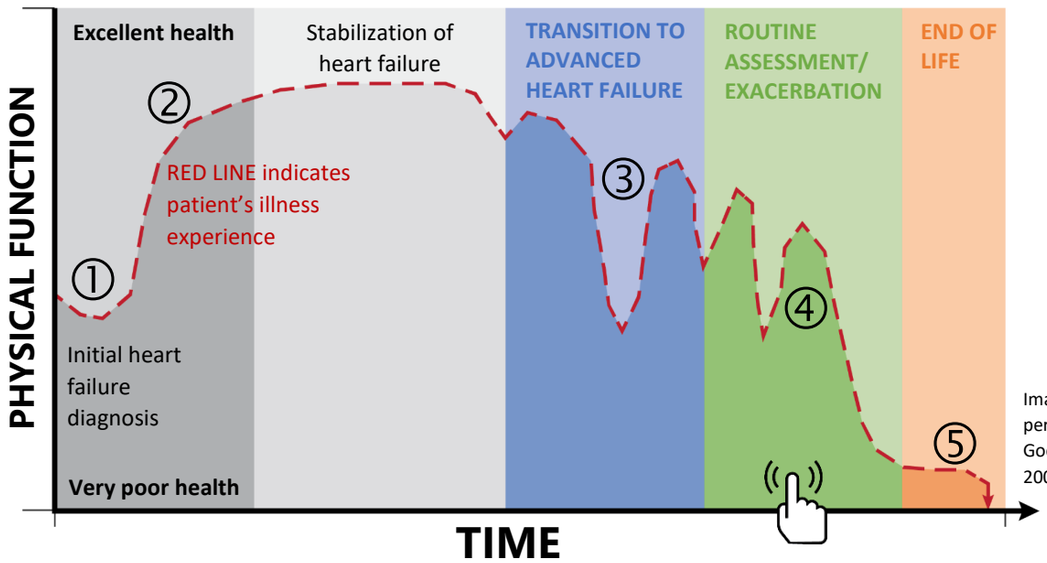


Image adapted with permission from Goodlin, SJ. JACC 2009;54: 386-96.

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February 2023

BRITISH COLUMBIA
doctors of bc
island health

SUPPORTIVE CARDIOLOGY TOOL

PHASE 1: Transition to Advanced Heart Failure

"My life is almost nothing compared to what it was. And every day gets harder." -Patient Quote

HOME

ALL PHASES

ILLNESS UNDERSTANDING

Does patient understand they have a serious illness?
Does patient have an understanding of HF trajectory?

HEALTH CARE PROVIDERS

What other formal caregivers are involved?
How active are they in the treatment?

MOST / CPR PREFERENCES

Does the MOST align with Serious Illness Conversation?
Do the patient and family have a copy of the MOST?
Is latest version in health authority's electronic medical record?

CALLING FOR HELP

Does the patient know who to contact for help and when?

Communications

PSYCHOSOCIAL

Communication Considerations for PHASE 1

PRIMARY SUPPORTS

Who are the patient's primary supports?
Who is the primary carer?

COMMUNICATION STYLE

What are the patient's communication preferences?
What do they want to know?
Who do they want to know this information?

DECISION MAKING

Who is the Temporary Substitute Decision Maker (TSDM)?
Do they need a Health Rep agreement?
Is the TDSM or Health Rep aware of patient's goals?
Does the patient's family agree with goals of care?

Medical Considerations

BIOMEDICAL

ASSESS & TREAT SYMPTOMS OF ADVANCED HEART FAILURE

Assess and treat the following symptoms of advanced heart failure:

- Dyspnea
- Pain
- Fatigue
- Constipation
- Anorexia
- Nausea
- Dry mouth
- Delirium
- Dizziness
- Itch
- Anxiety
- Depression
- Insomnia
- Peripheral edema
- Ascites

Medical Considerations for PHASE 1

MAXIMIZE HEART FUNCTION

Is ejection fraction known?
Is their ejection fraction below 40%?

What medications are optimizing their heart function?
Have they been maximized to target dose, but still tolerable?
How do you know if it is at target dosing?

OPTIMIZE TREATMENT OF COMORBIDITIES

What other comorbidities do they have?
Do they have cardiac cachexia or reduced exercise capacity?

Daily Life Function

MOOD

Any changes in mood according to patient or family?

SELF-CARE & COGNITION

How is the patient coping?
Is cognition affected (as noted by patient or family)?

Is patient coping well at home?
Do they need care supports?

DRIVING

Is the patient still driving?
Do they need a driving assessment?

FRAILTY

How frail is the patient?
Are they at high risk for falls?

SLEEP

Is the patient sleeping enough?

MEDICATION MANAGEMENT

How are the patient's medications managed?

DIET

Is the patient meeting daily diet requirements?
Do dietary restrictions / preferences align with goals of care?

ELIMINATION

Are they having issues with urinary continence?

SUPPORTIVE CARDIOLOGY TOOL

PHASE 2: Routine Assessment / Exacerbation

"Looking for peace of mind…by that I mean don't sugar coat or hide anything from me. Give me the facts and give me your advice and opinion in a timely fashion in a form I can understand." - Patient Quote

HOME

ALL PHASES

ILLNESS UNDERSTANDING

Does patient understand they have a serious illness?
Does patient have an understanding of HF trajectory?

HEALTH CARE PROVIDERS

What other formal caregivers are involved?
How active are they in the treatment?

MOST / CPR PREFERENCES

Does the MOST align with Serious Illness Conversation?
Do the patient and family have a copy of MOST?
Is latest version in health authority's electronic medical record?

CALLING FOR HELP

Does the patient know who to contact for help and when?

Communications

PSYCHOSOCIAL

Communication Considerations for PHASE 2

CARER EMOTIONAL SUPPORT

Who is supporting the carer?

PETS

Is there a plan for pets when hospitalized or upon death?

RESPITE

Does carer need respite support?

PERSONAL AFFAIRS

Does patient have an updated Will/POA/Health Rep?
Has the patient made funeral arrangements?

DECISION MAKING

What is the family's understanding of goals of care?
What is the family's agreement with patient's goals of care?

MEDICAL ASSISTANCE IN DYING (MAID)

Is patient asking about MAID?
Have they expressed suffering despite optimal medical care?

Medical Considerations

ASSESS & TREAT SYMPTOMS OF ADVANCED HEART FAILURE

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- Anxiety
- Depression
- Insomnia
- Peripheral edema
- Ascites

Medical Considerations for PHASE 2

MAXIMIZE HEART FUNCTION

Review medications for appropriate prescribing based on survival & symptom guided approach.
How is patient monitoring weight and vitals?

ICD DEACTIVATION

Do they have an active ICD?
Does their active ICD still align with their goals?
When is their next pacemaker appointment?

Daily Life Function

BIOMEDICAL

MOOD

Any changes in mood according to patient or family?

SELF-CARE & COGNITION

How is the patient coping?
Is cognition affected (as noted by patient or family)?

Is patient coping well at home?
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How are the patient's medications managed?

DIET

Is the patient meeting daily diet requirements?
Do dietary restrictions / preferences align with goals of care?

ELIMINATION

Is patient having issues with urinary continence?

Daily Life Function for PHASE 2

DISABILITY PARKING SUPPORTS

Does patient need disabled parking permit?
Do they need to connect to Handi-dart?
Do they need to connect with a taxi company?

FINANCIAL SUPPORTS

How is patient & family managing financially?
Are they able to buy necessary medications?

Is someone off work caring for patient or considering it?

SUPPORTIVE CARDIOLOGY TOOL

PHASE 3: End of Life

(Regarding the initiation of palliative care supports at home) "…There's all these people coming to see us…and 'this is what we're going to get for you' and bang, bang, bang – it's all here."

- Patient Quote

HOME

ALL PHASES

ILLNESS UNDERSTANDING

Does patient understand they have a serious illness?
Do they understand the HF trajectory?

HEALTH CARE PROVIDERS

What other formal caregivers are involved?
How active are they in the treatment?

M.O.S.T. / C.P.R. PREFERENCES

Is the MOST in line with Serious Illness Conversation?
Do the patient and family have a copy of the documents?
Is latest version in health authority's electronic medical record?

CALLING FOR HELP

Does the patient know who to contact for help and when?

CULTURAL & SPIRITUAL CONSIDERATIONS

Are there cultural/spiritual considerations about end of life to be aware of?

Communications

PSYCHOSOCIAL

Communication Considerations for PHASE 3

PROCESS OF DYING

Does patient or family have questions about process of dying?
Do they have questions about MAID?

END OF LIFE CARE

Clarify the desired location for end of life care- home, hospital or other facility?
If at home, do they have an *expected death in the home* (EDITH) form?

FUNERAL PLANNING

Does the patient have funeral plans made?
Does the Executor know the funeral home chosen?

CARER SUPPORT

Does the carer need counselling and/or bereavement support?

Medical Considerations

BIOMEDICAL

Medical Considerations for PHASE 3

ASSESS & TREAT SYMPTOMS OF ADVANCED HEART FAILURE

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- Anxiety
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- Insomnia
- Peripheral edema
- Ascites

MAXIMIZE HEART FUNCTION

Review medications for support symptoms only.

ICD DEACTIVATION

Is the patient near death with an active ICD?

Daily Life Function

SELF-CARE & COGNITION

Is patient coping well at home?
Do they need care supports?

MEDICATION MANAGEMENT

How are the patient's medications managed?

DIET

Is patient meeting daily diet requirements?
Do dietary restrictions / preferences align with goals of care?

ELIMINATION

Is patient having issues with urinary continence?

ILLNESS UNDERSTANDING

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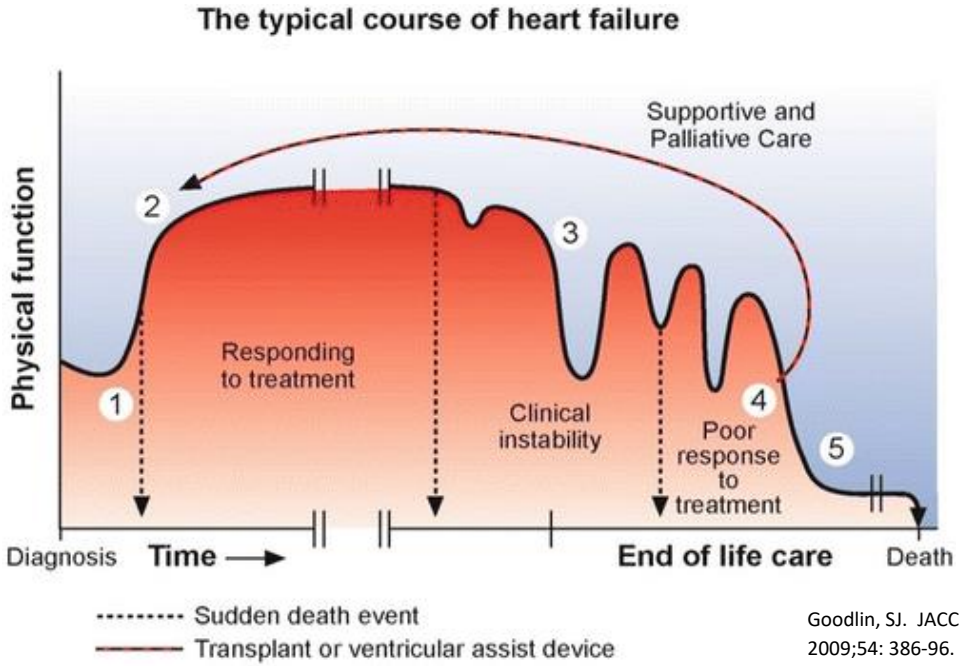
Does the patient understand they have a serious illness?
Does patient understand their HF trajectory?

- Review disease trajectory.
- Tell patient they have reached a serious stage of their heart failure now.
- Convey that the cardiac medications are not working as well anymore.
- Have a "Serious Illness Conversation" to identify the patient's goals/priorities in context of their illness.

Serious Illness Conversation Guide- Advance Care Planning (Fraser Health)



Goodlin, SJ. JACC 2009;54: 386-96.

ALL 3 PHASES

HEALTH CARE PROVIDERS

What other formal caregivers are involved?
How active are they in the treatment?

- Update other physicians, nurses & other care providers involved in the patient's care with any changes in management and/or major decisions that have been made by the patient & family. This update should include major topics of advance care planning discussed, and decisions made.
- Consider sending a patient summary proactively to the hospital via fax or EMR.
- In discussion with the other providers, determine the best ways to communicate information with Cardiologist, Home Care Nurse and other health care providers.

ALL 3 PHASES

M.O.S.T. / C.P.R.

Does the MOST align with Serious Illness Conversation?
Do the patient and family have a copy of the MOST?
Is the latest version in health authority's electronic health record?

Fraser Health
Medical Orders for Scope if Treatment (MOST) form
MOST brochure ✉

Interior Health
Medical Orders for Scope of Treatment (MOST) form
Medical Order for Scope of Treatment (MOST) brochure

Island Health
Medical Orders for Scope of Treatment (MOST) form
MOST Information for Patients and Families - Tools for Conversations ✉
Advance Care Planning MOST – Pamphlet ✉
Advance Care Planning MOST – Video ✉

Northern Health
Medical Orders for Scope of Treatment (MOST) form

Vancouver Coastal Health
Medical Orders for Scope of Treatment (MOST) form

CALLING for HELP

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Does the patient know who to contact for help and when?

- Educate patient and family regarding:
    - Signposts - signs that attention is required to their health status
    - Red flags – concerning things they should act on
    - Actions required.
- Specifically identify when/in what circumstance you want the patient to contact you.
- Identify when they should contact Home Care Nurse / Primary Care Provider / Hospice / 911.
- Clarify if you will be meeting in-person, virtually, on the phone, etc.
- Consider the burden on patient and family regarding the frequency and manner of visits.

Heart Failure Zones (Heart & Stroke) ✉

CULTURAL & SPIRITUAL CONSIDERATIONS

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Are there cultural / spiritual considerations to be aware of?

Consider whether the family would have any important practices after death that may need consideration as end of life approaches.

Living My Culture ✉

ASSESS & TREAT SYMPTOMS OF ADVANCED HEART FAILURE

ALL 3 PHASES

Assess and treat numerous symptoms of advanced heart failure.

- Adjust heart failure medications under target ranges if necessary to ease problematic symptoms (e.g. hypotension).
- BUT continue heart failure medications if patient is tolerating them.
- Recommend daily weight monitoring (to adjust diuretics) and regular blood pressure checks if not too burdensome to patient and family.
- Consider adding low dose opioids for breathlessness.
- Consider referral to Palliative Care if:
    - Refractory symptom management challenges
    - Communication difficulties

CHF Pocket Guide

CHF – Heart Failure End-of-Life Symptom Management Guidelines (Cardiac Services BC)

MOOD

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Any changes in mood according to patient or family?

- Screen for depression and anxiety via validated tool (Patient Health Questionnaire).
- Treat as appropriate.
- With the patient's permission, connect with the patient's support person regarding the plan.

Depression – PHQ-9 (includes scoring info)

ALL 3 PHASES

SELF-CARE & COGNITION

How is the patient coping? Is cognition affected (as noted by patient or family)?
Evaluate supports and consider a formal cognitive assessment (MMSE) .

Mini-Mental State Exam (Heart & Stroke)

Are they coping well at home? Do they need care supports?

- Contact *Community Health Services Central Intake* or *Physician Connector* to set up or adjust home supports (nursing, OT & personal support worker, etc).
- If need supports, do they qualify for BC Palliative Benefits at this time?

BC Ministry of Health
Palliative Care Benefits ✉

Fraser Health
Home support services
Better at Home – Community Based Senior Support Services for Independent Living
Home & Community Care Intake ✉

Island Health
Home support services
Community Based Senior Support Services ✉
Case Management for Home Care ✉

Vancouver Coastal
Home support services
Home Health Intake Line ✉

DRIVING

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Is the patient still driving?
Do they need a driving assessment?

Consider driving assessment (i.e. enhanced roadside assessment)

Driver Medical Fitness Standards ✉

FRAILTY

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How frail is the patient?
Are they at high risk for falls?

- Have Home Care OT or PT do falls risk assessment.
- Use Clinical Frailty Score (CFS) to more accurately communicate with home care nursing and other providers regarding patient's status.
- If CFS is at 7 or greater, consider registration with palliative care benefits program.

CSHA Clinical Frailty Scale

Falls Resources for Seniors (HealthLink BC) ✉

Palliative Care Benefits (Government of BC) ✉

SLEEP

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Is the patient sleeping enough?

- Conduct a sleep hygiene review
- Consider PRN sleep medication:
    - Melatonin (1st choice)
    - Trazodone
    - Mirtazepine

Sleep – Wellness Module – Getting a Good Night's Sleep (Here to Help BC)

MEDICATION MANAGEMENT

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How are the patient's medications managed?

- Consider blister packs or in-home pharmacy medication management program for dispensing.
- Check in with home care nursing for collateral information when necessary.

DIET

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Is the patient meeting daily diet requirements?
Do dietary restrictions / preferences align with goals of care?

- While many carers focus on a proper diet, as the person gets sicker, the focus is on quality of life & comfort. As a result, at this late stage they may have any food and drink.
- Monitor for edema to adjust diuretics accordingly.
- As the patient gets closer to end of life, it is normal for them to stop eating & drinking. Normalize this process of natural dying for family.
- Consider referral to a dietician to optimize nutrition

Eating a Healthy Diet with Heart Failure ✉

ALL 3 PHASES

ELIMINATION

Is patient having issues with urinary continence?

- Assess if patient needs assistance in toileting with additional equipment in the home.
- Determine if they have access to incontinence products. Consider registering for Palliative Care Benefits for this to be covered.
- When no longer ambulatory, consider if they need a Foley catheter inserted by a home and community care nurse.

Palliative Care Benefits (Government of BC) ✉

PRIMARY SUPPORTS

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Who are the patient's primary supports?
Who is the primary carer?

- Identify who the support people are, and if patient is willing to share their health information with them.
- Consider asking the patient to bring their primary support person to the medical appointments.

COMMUNICATION STYLE

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What are the patient's communication preferences?
What do they want to know?
Who do they want to know this information?

- Note patient's communication preferences in the executive summary of chart/primary care summary. This summary should be sent to hospital PRN.
- Consider whether the patient prefers all the details or just the big picture.
- Assess who else needs to be present for these appointments to support them and hear the latest information about their illness and treatment plans.

DECISION MAKING

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Who is the Temporary Substitute Decision Maker (TSDM)?
Do they need a Health Representative agreement?
Is the TSDM or Health Rep aware of patient's goals?

If the patient indicates a preference for a decision maker that does not follow typical legal TSDM order, then work with patient to get a Section 9 health representation agreement in place.

Temporary Substitute Decision Maker (TSDM) – Role and Scope of Authority (Nidus)

Temporary Substitute Decision Maker (TSDM) – Health Care Decisions in BC (Nidus)

Does the family agree with goals of care?

If there is conflict within the family regarding the goals of care, ensure the patient has carefully considered their alternate decision maker and informed them of their wishes.

MAXIMIZE HEART FUNCTION

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Do you know the patient's ejection fraction?

If EF unknown, consider whether additional testing including an ECHO is in line with the patient's goals and how it would change management if known.

Is their ejection fraction below 40%?

- If YES, they have HFrEF = Heart Failure with reduced Ejection Fraction. Consider the gold standard therapy of a beta-blocker (carvediolol or bisoprolol), ACEi/ARB/ARNi, mineralocorticoid and SGLT2 inhibitors. If EF <35%, consider cardiology referral for device therapy.
- If NO, they have HFpEF = Heart Failure with Preserved Ejection Fraction. Consider the gold standard therapy of a mineralocorticoid only AND ensure medical treatment of other cardiac comorbidities (eg. A Fib, Amyloidosis, Valvular disease, HTN, etc.)

What medications are optimizing their heart function?
Have they been maximized to target dose, but still tolerable?
How do you know if patient is at target dosing?

- If not at target dosing, further titrate their medications as tolerated.
- If medications have been optimized, consider adding medications only focused on symptom control.
- If it is uncertain as to whether the patient's heart failure medical management is optimized, consider referral to cardiology or internal medicine.
- If urgent, contact a cardiologist on the RACELINE.
- Make adjustments to medications, follow up with visit within 2 weeks.
- Consider monthly follow up if stable; or as frequent as weekly PRN.
- See drug search.ca for costs, coverage by pharmacare and special authority

Rapid Access to Consultative Expertise (RACE)
CHF Pocket Guide
DrugSearch.ca – BC Drug Formulary & Price & Special Authority Search Tool

OPTIMIZE TREATMENT OF COMORBIDITIES

What other comorbidities does the patient have?

Adjust management and monitoring of other conditions including hypertension, diabetes, and COPD.

Do they have cardiac cachexia?

- Consider referral to Dietitian for nutritional support
- Consider referral to Cardiac Rehab to maximize muscle mass preservation.

Fraser Health

Cardiac Rehab and Prevention
Cardiac Rehab Referral form
Healthy Heart Program ✉

Interior Health

Cardiac Rehabilitation ✉

Island Health

Cardiac Rehab Referral form
Cardiac Rehabilitation Outpatient Clinic Program RJH
Cardiac Rehab Program brochure ✉
Cardiac Risk Reduction and Rehabilitation Program - poster

Vancouver Coastal & Providence Health

Regional Cardiology Referral Form
Cardiac Rehabilitation Clinic - Vancouver General Hospital

Links to Cardiac Rehab information

Cardiac Rehab and Metabolic Programs (North Vancouver)
Cardiac and Pulmonary Rehabilitation Programs (Prince George Family YMCA) ✉

CARER EMOTIONAL SUPPORT

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Who is supporting the carer?

- The carer is KEY to the patient being able to remain at home with maximum independence and quality of life.
- For additional support consider community counselling for the patient and carer (individually and/or jointly).
- Ask the patient to bring their primary support person (TSDM) to the medical appointments.

Caregivers Community Resource List and Financial Benefits (Doctors of BC) ✉

PETS

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Is there a plan for pets when the patient is hospitalized or upon death?

Consider ElderDogs to help seniors keep dogs at home or other volunteers to assist with pets.

Dog Care Support for Seniors (ElderDog) ✉

RESPITE

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Does carer need respite support?

- Consider the following options:
    - Home care nurse (HCN) providing in-home respite support.
    - Support network.
    - Stay at respite facility.

PERSONAL AFFAIRS

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Does patient have updated Will/POA/Health Rep?
Has the patient made funeral arrangements?

- Prompt patient to create or update a Will and to designate their power of attorney (POA).
- If the patient's choice of alternate decision maker does not fit the usual legal order, prompt patient to create or update Health Rep agreement and keep a copy on file and documented in the primary care summary sent to hospital prn (e.g. NIDUS link).

Representation Agreement Guide (NIDUS) ✉

Victoria Hospice – Memorial Decision Making and Planning Brochure ✉

Links to Funeral & Memorial services:
Funeral & Memorial Planning (BC Ministry of Health)
Funeral Support Services (Memorial Society of BC) ✉

MEDICAL ASSISTANCE IN DYING (MAiD)

Is patient asking about MAiD?
Have they expressed suffering despite optimal medical care?

If patient expresses suffering despite optimal medical care including escalating symptom support, explore whether they want information regarding MAiD.

Links to health authority MAiD programs

Guide to Support People Requesting MAiD (Fraser Health) ✉
Medical Assistance in Dying (MAiD) (Island Health) ✉
Medical Assistance in Dying (MAiD) (Interior Health) ✉
Medical Assistance in Dying (MAiD) (Northern Health) ✉
Medical Assistance in Dying (MAiD) (Vancouver Coastal Health)

MAXIMIZE HEART FUNCTION

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Review medications for appropriate prescribing based on survival and symptom guided approach.

- Consider which medications are providing symptom support and eliminate any that are not.
- Ensure patient is able to consume all medications, consider liquid formulas but consider ease of measuring dosages.
- Consider changing furosemide to subcutaneous dosing to alleviate pulmonary edema, even if kidney function poor.
- If you are not sure how to address the symptoms, reach out to your palliative care colleagues via the RACELINE.

RACE – Rapid Access to Consultative Expertise

CHF – Heart Failure – End of Life – Appropriate Prescribing Guidelines (Cardiac Services BC)

How is the patient monitoring weight and vitals?

Phase 2 only

- Consider referral to Home Health Monitoring if patient requires further monitoring for stabilization through home & community care services.
- If patient unable to continue monitoring weight and vitals, review signs of edema and update action plan.

CHF – Heart Failure Management Self-Check Plan (American Heart Association)

Community Virtual Care (Island Health) ✉

ADDRESSING AN IMPLANTABLE CARDIOVERTER DEFIBRILLATOR (ICD)

Do they have an active ICD?
Does their ICD still align with their goals?
When is their next pacemaker appointment?

- Discuss timing, conditions, or circumstances in which patient would consider deactivation of ICD.
- Send updated progress note/chart note to active care providers including Cardiologist & Home and Community Care.
- Give patients and families information on ICD deactivation if they will find it useful.
- Consider referral to Pacemaker Clinic to deactivate ICD before person becomes housebound (if possible).

Implantable Cardioverter Defibrillator (ICD) Deactivation – Patient Consent Form (BC's Heart Failure Network)

Deactivation of Implanted Cardioverter Defibrillator (ICD) Referral Form (BC's Heart Failure Network)

Care Pathway / Algorithm: CHF – Heart Failure – End of Life – Implantable Cardioverter Defibrillator (ICD) Deactivation Decision Algorithm

CHF – Implantable Cardioverter Defibrillator (ICD) Deactivation Guide (Heart & Stroke) ✉

Island Health
ICD Deactivation Referral Form (Island Health)
ICD Deactivation Consent Form (Island Health)

Interior Health
ICD Deactivation Referral Form (Interior Health)
ICD Deactivation Consent Form (Interior Health)

DISABILITY PARKING SUPPORTS

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Does patient need a disabled parking permit?
Do they need to connect to Handi-Dart?
Do they need to connect with a taxi company?

- Provide patient with disabled parking permit.
- Patient may apply for Handi-Dart support without physician referral.

Parking Permits for People with Disabilities (SparcBC) ✉

HandyDART (BC Transit) ✉ *'Change Transit System' to select your community transit*

FINANCIAL SUPPORTS

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How is patient and family managing financially?
Are they able to buy necessary medications?

- Complete/confirm registration with BC Palliative Care Benefits for medication and equipment coverage.
- Complete medical certificate for caregiving related to employment benefits.
- Accelerated CPP application if someone has to go off work and/or not on pension.
- If there are barriers, consider referral to social work through home and community care.

BC Palliative Care Benefits Registration Form ✉

Is someone off work caring for patient?
Is there someone considering doing so?

Complete the medical part of the Compassionate Care Benefits application for carer or Family Caregiver Benefit for adults.

Employment Insurance – Compassionate Care Benefit (Government of Canada) ✉

MEDICATION MANAGEMENT

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How are the patient's medications managed?

- Consider blister packs or in-home pharmacy medication management program for dispensing.
- As oral route becomes more difficult change medications to injectable versions of the most critical symptom medications, such as:
    - Furosemide (subcut bolus or infusion if necessary)
    - Opioids
    - Benzodiazepine
    - Antipsychotics (at a minimum)

Note: Once patient is bedbound and near end of life, continue to use furosemide +/- metalozone without regard for kidney function to avoid pulmonary edema.

PROCESS of DYING

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Does patient or family have questions about the process of dying?
Does the patient have questions about MAiD?

- Often you will need to describe the natural course of dying to family.Explain that sleeping more and eating less is a natural part of someone approaching end of life.
- If their suffering is intolerable, they may choose medical assistance in dying. You can refer to the Island Health MAiD office for more information.

End of Life – Final Days (Canadian Virtual Hospice)

Canadian Virtual Hospice ✉

Links to health authority MAiD programs
Guide to Support People Requesting MAiD (Fraser Health) ✉
Medical Assistance in Dying (MAiD) (Interior Health) ✉
Medical Assistance in Dying (MAiD) (Island Health) ✉
Medical Assistance in Dying (MAiD) (Northern Health) ✉
Medical Assistance in Dying (MAiD) (Vancouver Coastal Health)

END of LIFE CARE

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Clarify the desired location for end of life care – home, hospital, or other facility.
If at home, do they have an expected death in the home (EDITH) form?

- Ensure both the patient and the primary carer are in agreement regarding location.
- Some patients may want to die at home, but this might not be possible due to their care needs or carer limitations.
- EDITH form must be completed by **same physician who will complete death certificate** and sent in advance to the patient's chosen funeral home. Family will wait 1 hour after death before calling funeral home, no professional required to pronounce death.

Home Death – Planning for Expected Death at Home (Ministry of Health) ✉

FUNERAL PLANNING

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Does the patient have funeral plans made?
Does the Executor know the funeral home chosen?

- Provide the patient and family with information on funeral planning.
- Encourage the patient to talk to their family members about their funeral plans and wishes.

Links to Funeral & Memorial services:
Funeral & Memorial Planning (BC Ministry of Health)
Funeral Support Services (Memorial Society of BC) ✉

CAREER SUPPORT

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Does the carer need counselling and/or bereavement support?

- Consider referring the carer for counselling through a local hospice or other counselling services.

Grief and Bereavement BC Helpline ✉

Caregiver Support – Family Caregivers of BC ✉

ICD DEACTIVATION

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If patient is near death, do they have an active ICD?

- Deactivate with donut magnet taped in place until properly deactivated through programming.
- Contact pacemaker clinic to arrange proper deactivation. NOTE: This may require the patient being transported by non-urgent ambulance to pacemaker clinic.

Implantable Cardioverter Defibrillator (ICD) Deactivation – Patient Consent Form (BC's Heart Failure Network)

Deactivation of Implanted Cardioverter Defibrillator (ICD) Referral Form (BC's Heart Failure Network)

Care Pathway / Algorithm: CHF – Heart Failure – End of Life – Implantable Cardioverter Defibrillator (ICD) Deactivation Decision Algorithm

CHF – Implantable Cardioverter Defibrillator (ICD) Deactivation Guide (Heart & Stroke) ✉

Island Health
ICD Deactivation Referral Form (Island Health)
ICD Deactivation Consent Form (Island Health)

Interior Health
ICD Deactivation Referral Form (Interior Health)
ICD Deactivation Consent Form (Interior Health)