

Free literature review on care of people with heart failure

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Care of People with Heart Failure

Introduction

The constantly increasing number of people suffering from heart failure and other chronic conditions is always raising concern about the quality of health services accorded to these people. Admittedly, improving health care has emerged as one of the urgent issues around the world with governments, health care administrators and physicians, just to mention but a few, letting their policy objective be appreciably influenced by the desire to improve health care delivery, particularly for chronic and long term illnesses. This paper aims at describing the best model for care for heart failure. The paper also describes how models of care and treatment settings are integrated and coordinated to ensure a continuous provision of quality care for the patient and what governments and health services can do to improve the delivery of service to these patients besides recommending measures that can further better the model care for heart failure patients.

Model of Care for Heart failure

Heart failure is a clinical heart disease that results from and underlying damages to the heart structurally and functionally hence weakening the pumping function of the heart leading to the hearts inability to supply the body with oxygen and other nutrients carried in the blood stream effectively (Ferrell & Coyle 2010). Even as researches depict that the prevalence of heart diseases, particularly heart failure, have declined over the years, it is still indubitable that heart diseases still remain the leading killer diseases in United States (Hupcey 2010). Heart failure is perhaps the most widespread

heart disease in the world over with an estimated 5 million Americans having heart failure. The yearly incidence of heart failure in America according to Adler et al. (2009) is estimated as more than 500 000 and in 2004 for instance, close to 300 000 died of heart failure; this was more than the number of deaths caused by lung, breast and prostate cancer and HIV/AIDs combined. Even with the advances in evidence based care for heart failure being witnessed, the survival rates for heart failure victims is still remarkably low compared to the survival rates of cancer victims.

The State of Western Australia Department of Health (2008) proposes that a model of care for heart failure should build on the knowledge, best practice and existing programs and services (Australian Department of Health Care, 2008). On their part, Johnson & Lehman (2006) assert that there is no universally accepted model of care for heart failure perhaps because heart failure describes a wide spectrum of conditions with its victims having health care demands that are often not purely medical. However, over the years, Palliative care has risen to be one of the major models of care for heart failure. It is notable that the palliative care movement began in the 1970s as a “grassroot community hospice movement” whose intention was to care for cancer patients in their homes (Adler et al. 2009). The establishment was based on the research findings that exposed that people suffering from diseases such as cancer and heart failure were often left to live lives marked with unnecessary and avoidable sufferings (Fordham, Dowrick & May 1998; Adler et al. 2009). Later, the non hospice palliative care was to be founded with a primary intent of improving the quality of life of chronic illnesses victims in whom prognosis had proved uncertain (Adler et al. 2009).

Assertively, Palliative care aims at ameliorating the quality of life lived by the patient and family members of patients with grievous illnesses based on the provision of pain and symptom relief strategies, as well as a psychosocial support from diagnosis to perhaps death and bereavement of the patient (Hupcey 2010; Jaarsma et al. 2009; Fordham, Dowrick & May 1998). The practice of palliative care for heart failure involves the assessment of the symptoms showcased by the patient that makes use of the Edmonton Symptoms Assessment Scale (ESAS) completed by the nurse, the patient or relatives of patients. After the identification of the symptoms, the patient is placed in a symptom management program that essentially entails the management of the of the individual symptoms initially identified as well as any symptom that might be exhibited after the assessment has been done. It should be noted that the essence of palliative care is always underscored by the fact that the survival rates of patients with heart failure is always remarkably low hence patients with heart failure always end up having exceedingly poor quality of lives that is marked with incessant admissions into hospital.

Integration and Coordination of care of Continuity

As Johnson & Lehman (2006) note, dying from a heart failure might be an unusually long and abominable experience that involves exhaustion on the part of the patient, and likewise, the care giver. Studies on the experiences of heart failure patients have always revealed that it is always an unpredictable time which cannot be effectively managed through any curative means. Leading a poor in all phases of heart failure is an expected

feature which warrants that palliative care should last as long as the patient has not succumbed to the condition. In this regard, palliative care is always designed in a manner that the care continues even when the patient has been discharged from the hospital (Guest, Ruiz, Greener, & Trotman 2006; (Sepúlveda, Marlin, Yoshida & Ullrich, 2002). Apparently, the primary care givers in a palliative care are family members who are trained and constantly obtain instructions from a palliative care nurse on the needed health care of as heart failure patient. Nonetheless, it should be noted that the capriciousness of heart failure conditions is always an indispensable threat to an effective provision of palliative care to a heart failure patient (Johnson & Lehman 2006).

Additionally, as Jaarsma et al. (2009) asseverate, palliative care for heart failure is designed to run through the three principal stages of heart of heart failure. For example, during the first phase of the disease, palliative care goals encompass; active monitoring, symptom control, as well as patient and carer education, just to mention a few (Jaarsma et al. 2009). During the second phase of the condition, the patient might be admitted, and a professional identified to coordinate the care of this patient (Jaarsma et al. 2009). Additionally, a multidisciplinary assessment of the patient and the care giver is undertaken with the elementary goal of care shifting to the provision of optimal control of symptoms. The terminal stage of heart failure is marked with the continuation of optimal symptom control. This gives insight to the unending strategy of implementation of palliative care.

What the literatures reviewed recommend

Even as palliative care is reckoned as one of the soundest model care for heart failure, it can still be ameliorated further if certain facets are taken into consideration. Jaarsma et al. (2009) recommend that the effectuality of palliative care be enhanced with a consistent review of the goals of the care program together with the development of a working collaboration strategy of the care givers and primary care providers. Daley, Matthews and Williams (2006) also refer to the recommendations by NICE (The National Institute for Clinical Excellence) that supportive care should be made of components such as self help and support, user involvement, psychological support as well as spiritual support among others. NICE, as reported by Daley, Matthews and Williams (2006), also purports that supportive care should not be deemed as a distinct specialty but as a joint responsibility of all the stakeholders including all social and health care professionals involved. The State of Western Australia Department of Health(2008) on their part recommends that; statewide evidence-based guidelines together with patient pathways should be developed for the detection, prevention and management of the heart, heart failure patients should have access to all-important services that ensure the lead the recommended quality of life, governments should invest in IT that is widely known to be utilitarian in data collection and also a resource center should be developed with a scope that encompasses the communities and the hospitals. These should also be followed with the establishments of partnerships with relevant organizations in a bid to develop working strategies to aid in an effective implementation of palliative care as a model care for heart failure. WHO also recommends that countries

should develop palliative care programs to ensure that people with malignant illnesses together with their families lead a quality life.

The Role of Governments and health services in improving the delivery of service to heart failure patients

The government and health care practitioners have a polar role with regards to the provision of palliative care. It is worthy of noting that the funding of palliative care is relatively expensive hence should not be left to the families of the patients alone. The government and policy makers have a function to play in funding the palliative care one of the strategies of ensuring that everyone has a last moment quality life (National Hospice and Palliative Care Organization 2010). Additionally, several governmental hospitals have been seen developing palliative care units as one of the strategies of improving the delivery of palliative care.

Conclusion

Concisely, heart failure is a cardiac condition in which the heart's responsibility of pumping the blood is handicapped following a structural or a functional damage of the heart particularly by a disease of the heart. In the ends, the heart is incapacitated to pump blood effectively. Palliative care- a model of care whose basic principle centers on the provision of quality care malignant illnesses' patients- is one of the widely used models of care for heart failure. With a relatively rich history that dates back to the 1970s, provision of palliative care begins with the assessment of the symptom exhibited by a heart failure patient before the patient is placed in a symptom management program to improve the symptoms. Nonetheless, as seen

above, the model can be bettered further with the implementation of the highlighted recommendations, for instance, increased funding by the government.

Reference List

- Adler, E. D., Goldfinger, J. Z., Kalman, J., Park, M. E. & Meier, D. E. 2009. Palliative Care in the Treatment of Advanced Heart Failure. *Journal of the American heart Association*, vol. 120, pp.: 2597-2606.
- Daley, A., Matthews, C., & Williams, A. 2006, Heart failure and palliative care services working in partnership: report of a new model of care. *Palliative Medicine*, vol. 20, 593-601.
- Ferrell Betty R., Coyle, N., 2010, *Oxford Textbook of Palliative Nursing*. Oxford University Press, New York, NY.
- Fordham, S., Dowrick, C. & May, C. 1998, Palliative Medicine: Is It Really Specialist Territory? *Journal of the Royal Society of Medicine*, vol. 9, pp. 568-572.
- Guest, J. F., Ruiz, F. J., Greener, M. J., Trotman, I. F. 2006, Palliative care treatment patterns and associated costs of healthcare resource use for specific advanced cancer patients in the UK. *European Journal of Cancer Care*. Vol. 15, no. 1, 65-73.
- Hupcey, J. E. A Model of Palliative Care for Heart Failure. *American Journal of Hospice Palliative Care*. vol. 26, no. 5, pp. 399-404.
- Jaarsma, T., Beattie, J. M., Ryder, M., Rutten, F. H., McDonagh, T., Mohacsi, P., Murray, S. A., Grodzicki, T., Bergh, I., Metra, M., Ekman, I., Angermann, C., Leventhal, M., Pitsis, A., Anker, S. D., Gavazzi, A., Ponikowski, P., Dickstein,
- <https://assignbuster.com/free-literature-review-on-care-of-people-with-heart-failure/>

K., Delacretaz, E., Blue, L., Strasser, F., & McMurray, J. 2009, Palliative care in heart failure: a position statement from the palliative care workshop of the Heart Failure Association of the European Society of Cardiology. *European Journal of Heart Failure*, vol. 11, pp. 433-443.

Johnson, M., Lehman, R., 2006, *Heart Failure and Palliative Care: A Team Approach*. Radcliffe Publishing Ltd, Oxon, OX.

National Hospice and Palliative Care Organization, 2010, *NHPCO Facts and Figures: Hospice Care in America*, pp. 1-15.

Sepúlveda, C., Marlin, A., Yoshida, T., & Ullrich, A. 2002, Palliative Care: The World Health Organization's Global Perspective, *Journal of Pain and Symptom Management*, vol. 24, no. 2, pp. 91-96.

State of Western Australia Department of Health, 2008, *Heart Failure Model of Care*. Health Networks Branch, Department of Health, Western Australia, Perth.

Wright, M., Hamzah, E., Phungrassami, T., Bausa-Claudio, A. 2010, *Hospice and Palliative Care in Southeast Asia: A review of developments and challenges in Malaysia, Thailand and the Philippines*. Oxford University Press, New York, NY.