



**CorHealth
Ontario**

*Advancing cardiac, stroke
and vascular care*

Chronic Heart Failure:

General Information and Practical Tips for
Health Care Providers

About CorHealth Ontario

As of June 22, 2017, we are CorHealth Ontario, an organization formed by the merger of the Cardiac Care Network of Ontario and the Ontario Stroke Network, with an expanded mandate spanning cardiac, stroke and vascular care. CorHealth Ontario proudly advises the Ministry of Health and Long Term-Care, Local Health Integration Networks, hospitals, and care providers to improve the quality, efficiency, accessibility and equity of cardiac, stroke and vascular services for patients across Ontario. For more information, visit corhealthontario.ca.

This document was prepared by the Cardiac Care Network (CCN). The contents and other materials contained in this document (the "Content") do not constitute, and are not intended to be and should not be construed as patient specific professional medical advice, diagnosis or treatment. Readers should apply their own qualified medical and professional opinion when considering and/or applying the information contained herein to specific patient circumstances. Never disregard professional medical advice or delay in seeking it because of something you have read in this document. The inclusion of any link or external reference in this document does not constitute CCN's endorsement of the linked site or its affiliates, or any information, content, products, services or any other materials presented on or through such websites. This document reflects the interpretations and recommendations regarded as valid at the time it was published based on available information. CCN will not be held responsible or liable for any harm, damage, infringement or other losses resulting from any reliance on, or reproduction, communication to the public, use or misuse of, the information and/or Content contained in this document.

Table of Contents

2	What is Heart Failure?	16	Medication Pathway for Chronic Heart Failure
3	Heart Failure and Ejection Fraction	18	Medication Chart
4	Symptoms of Heart Failure	20	Medication Tips
6	NYHA Classifications	27	Self-Care Process
8	Severity & Status of Heart Failure Symptoms	28	Factors Affecting Self-Care
12	Exam Findings That Specifically Relate to Heart Failure	32	Advance Care Planning

What is Heart Failure?

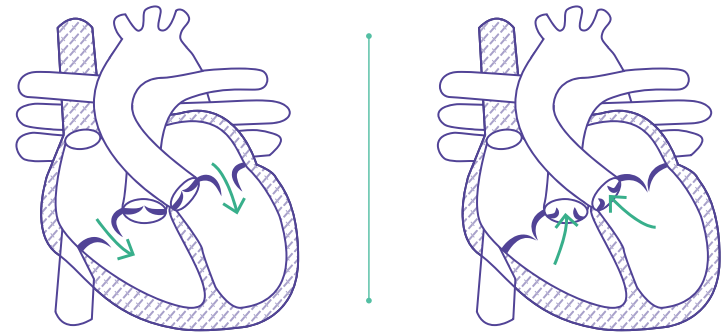
Heart failure (HF) is a condition when the heart is unable to pump enough blood to meet the metabolic demands of the body.

The most common symptoms of heart failure include: shortness of breath (SOB), fatigue, and edema. Heart failure symptoms can occur in the absence of fluid overload or 'congestion', and therefore the term 'congestive heart failure' has been changed to 'heart failure'.

Although there are many causes of HF, the most common causes include coronary artery disease and hypertension.

Heart Failure and Ejection Fraction (EF)

Left ventricular ejection fraction (LVEF): The % of blood pumped out of the left ventricle with each beat. Normal LVEF >55%



HF with preserved EF:
LVEF > 40% ('HF-pEF')

Stiff Heart Muscle
Trouble filling during ventricular diastole

HF with reduced EF:
LVEF ≤ 40% ('HF-rEF')

Weak Heart Muscle
Trouble ejecting blood during ventricular systole

Symptoms of Heart Failure

Shortness of breath (SOB) and fatigue are the most commonly reported symptoms of HF. The following section outlines a number of symptoms that can be related to HF.

Symptoms	Description
Shortness of Breath (SOB)	<ul style="list-style-type: none"> • Usually occurs on exertion or, with more severe HF can occur at rest • Can be a result of many reasons beyond fluid in the lungs including, but not limited to: inadequate cardiac output, fluid retention, deconditioning, or skeletal muscle weakness
Fatigue	<ul style="list-style-type: none"> • Decreased exercise tolerance • Can be a result of many reasons including, but not limited to: inadequate cardiac output, fluid retention, deconditioning, or skeletal muscle weakness
Peripheral Edema	<ul style="list-style-type: none"> • May be present in the lower extremities, abdomen, sacrum, scrotum or generalized

Symptoms	Description
Orthopnea	<ul style="list-style-type: none"> • SOB when lying flat • Need to prop up their head to avoid SOB (e.g. extra pillows) • Occurs due to redistribution of fluid from lower extremities when lying recumbent, increasing pulmonary capillary pressure
Paroxysmal Nocturnal Dyspnea (PND)	<ul style="list-style-type: none"> • Wake up suddenly with severe SOB • Anxiety and a sense of suffocation may be associated symptoms • Occurs due to redistribution of fluid from lower extremities when lying recumbent, leading to pulmonary edema
Cough	<ul style="list-style-type: none"> • Chronic, non-productive cough worse when lying down is often associated with pulmonary congestion • May be due to pulmonary, cardiac or gastric causes or may be a side effect of medication (e.g. ACE inhibitor)
Wheezing	<ul style="list-style-type: none"> • May be present at rest or with exertion and occurs in the setting of fluid overload • May be caused by congestion of bronchial mucosa and compression of small bronchi

Symptoms	Description
Gastrointestinal Symptoms	<ul style="list-style-type: none"> Abdominal fullness/bloating/discomfort, nausea, poor appetite, early satiety, constipation May be due to ascites, gut edema, passive liver congestion with fluid retention Constipation may be due to fluid shifting from intravascular space into tissues
Weight Gain	<ul style="list-style-type: none"> Rapid weight gain: 2 pounds (1 Kg)/day or 5 pounds (2 Kg)/week
Atypical Symptoms	<ul style="list-style-type: none"> More common in the elderly May include functional decline, falls, depression, insomnia or nocturia, delirium (“Nights are bad”).

NYHA Classifications

The New York Heart Association (NYHA) classification system is used to describe the level of functional impairment from HF symptoms. It helps define treatment goals and modalities. Patients may fluctuate between the NYHA classes representing periods of exacerbation and the need for urgent or acute care.

Note, there is no relationship between the strength of the heart muscle and NYHA class. For example, a person with a low ejection fraction may have NYHA Class 2 symptoms while someone else with a normal ejection fraction may have NYHA Class 3 symptoms.

NYHA Class Symptom Severity

1 No limitation of physical activity. Ordinary physical activity does not cause fatigue, palpitations, or SOB.

2 Slight limitation of physical activity. Mild HF symptoms (SOB, angina) during ordinary physical activity.

3 Moderate limitations of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitations or SOB.

4 Symptoms of heart failure at rest. Unable to carry out physical activity without discomfort.

Severity and Status (e.g. same/better/worse) of HF Symptoms

It is important to note the current status of a person's HF symptoms, in addition to determining if they are the same/better/or worse.

Note: If a person's HF symptoms are getting worse, try to problem solve to identify possible triggers for the change. Identifying and managing the trigger(s) is required for improving and stabilizing HF symptoms.

Questions to Ask	Clinical Concerns to Report
Current level of activity and limiting factor	
If you and I could go for a walk, your pace, no hills, how long could you walk for?	<ul style="list-style-type: none"> Declining functional capacity
What would limit you from walking any further (e.g. breathing, fatigue, arthritis)?	
How does this compare to what you did last month/week (time frame dependent on patient situation)?	

Questions to Ask	Clinical Concerns to Report
SOB	
What types of activities make you short of breath?	<ul style="list-style-type: none"> Increasing SOB or SOB at rest
Are there any of your usual activities you are avoiding because they will make you short of breath?	
Orthopnea	
How many pillows do you sleep with under your head?	<ul style="list-style-type: none"> Any symptoms of orthopnea
Is the head of your bed elevated?	
Do you sleep in a chair or recliner?	
If yes, does your breathing get better when you sit up? How frequent are these episodes?	
Paroxysmal Nocturnal Dyspnea (PND)	
Do you wake up suddenly in the middle of the night gasping for air? Does it seem better when you sit up?	<ul style="list-style-type: none"> Any symptoms of PND
How frequent are these episodes?	

Questions to Ask	Clinical Concerns to Report
Peripheral Fluid Retention	
<p>Have you noticed any swelling in your feet or ankles?</p> <p>Can you fit into your socks or regular shoes?</p> <p>Does this swelling go away by the next morning?</p> <p>Do you feel like your belly/abdomen is bloated? (If yes, are you constipated?)</p> <p>Has your daily weight changed? (If yes, how much weight increase and time frame?)</p>	<ul style="list-style-type: none"> • Edema that does not resolve by the next morning • Abdominal fullness in the absence of constipation • Weight gain of 2 pounds (1Kg)/ day or 5 pounds (2 Kg)/ week
Frail Seniors – Atypical Symptoms	
<p>Inquire with the care giver about sudden changes in cognition or function, or if person is ‘no longer themselves’.</p> <p>(If yes, explore possible reasons for this change such as worsening heart failure.)</p>	<ul style="list-style-type: none"> • Any new changes

Questions to Ask	Clinical Concerns to Report
Volume Depletion	
<p>Do you ever get lightheaded? (If yes, explore situation further)</p> <p>Have you had any falls? (If yes, explore situation further)</p> <p>Has your daily weight changed? (If yes, how much weight loss and time frame)</p>	<ul style="list-style-type: none"> • It is normal to have some postural light headedness; however, it should not interfere with regular activities or be unsafe • Any episodes of falling or syncope • Weight loss of > 2 pounds (1 Kg)/ day or 5 pounds (2 Kg)/ week • Diarrhea for more than 2 days
Arrhythmia	
<p>Do you ever feel like your heart is racing and it makes you feel unwell? (If yes, explore situation further)</p> <p>Have you ever fainted? (If yes, explore situation further)</p>	<ul style="list-style-type: none"> • Prolonged palpitations • Fainting (syncope)

Exam Findings That Specifically Relate to Heart Failure

General Appearance

- Does the patient look well, ill or malnourished?
- Does the patient look frail?
- Use of assistive devices
- Skin colour, presence of pallor or cyanosis
- Shortness of breath or orthopnea during the visit or exam?
(Tip – Are they tachypneic, or exhibiting respiratory distress or wheezing either at rest, or more when lying back?)
- Pitting edema - feet, ankles, legs, sacrum (can they fit into their shoes?)
- Current weight and any changes in weight in the last week?

Vital Signs

- There is no consistent change in vital signs that always indicates fluid overload
- Heart rate and blood pressure readings must be interpreted in combination with other findings. Check for postural drop in blood pressure to assess for fluid depletion (e.g. diuretics too strong).
- Low blood pressure is not unusual
- Low blood pressure is a concern if patients feel unwell, lightheaded, dizzy, more tired than usual or report falling or fainting
- Consult with a physician before advising a patient not to take heart failure medications when blood pressure is low
- For medication tips in the setting of low blood pressure, see page 21

Jugular Venous Pressure (JVP)

- The JVP reflects the ability of the heart to accommodate venous return. The JVP can be elevated when someone has increased fluid volume, even in the absence of peripheral edema.
- When people complain of abdominal bloating but have no obvious edema- JVP can be a great clue for fluid status.
- Normal JVP \leq 4 cm above the sternal angle
- Quick clue- if you can see the JVP while they are sitting, it is elevated
- JVP- “fat when flat“- easiest to see when someone lying down
- The JVP can also be increased for other reasons such as: tricuspid regurgitation; pulmonary hypertension; complete heart block (right atrium contracting against a closed tricuspid valve)

Pulmonary Assessment

- Crackles – not cleared by coughing, caused by excessive fluid in the airspaces
- Crackles in early inspiration denote CHRONIC condition, crackles at end inspiration more often indicate fluid in the airspaces (heart failure)
- Wheezes – may be caused by bronchial edema from worsening HF. Can be on inspiration or expiration

Hemoptysis: Frank blood, or pink tinged frothy sputum is indicative of acute pulmonary edema due to rupture of engorged bronchial veins, anticoagulation may worsen. (Often a medical emergency).

Note: Some patients may have relatively clear lungs on examination but can still be fluid overloaded.

Medication Pathway for Chronic Heart Failure (LVEF \leq 40%)

Source:

CCS Guidelines, 2021
(www.ccs.ca)

ACE inhibitor

Angiotensin converting enzyme inhibitor

ARNI

Angiotensin Receptor - Nephilysin Inhibitor

ARB

Angiotensin II Receptor Blocker

BB

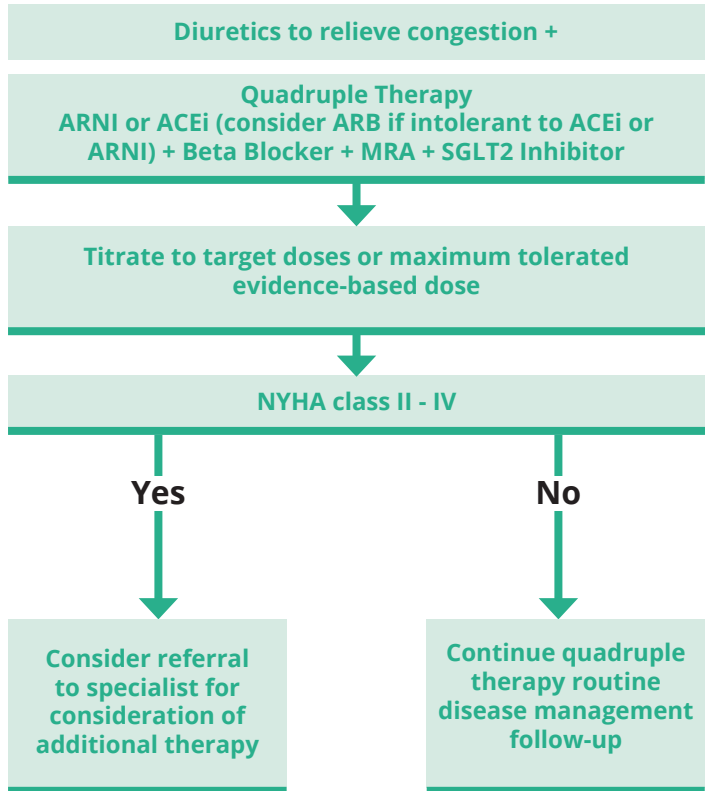
Beta blocker

MRA

Mineralocorticoid receptor antagonist

SGLT2 Inhibitor

Sodium-glucose Cotransporter



Note: The approach to medication choices and doses may vary and depend on the clinical scenario and other patient factors including renal function, hemodynamic status, anticipated side effects, tolerability, access to medication, adherence and patient preference.

LVEF > 40% Medication

- Control of hypertension per current guidelines is critical
- Control of resting heart rate <70 bpm, especially if atrial fibrillation present

Medication Chart for Chronic Heart Failure (LVEF \leq 40%)

	Drug	Start Dose	Target Dose
ARNI	Sacubitri/Valsartan (Entresto™)	50-100 mg BID	200 mg BID
ACE INHIBITOR	Enalapril	1.25 - 2.5 mg BID	10 mg BID
	Lisinopril	2.5-5 mg daily	20-35 mg daily
	Perindopril	2-4 mg daily	4-8 mg daily
	Ramipril	1.25-2.5 mg BID	5 mg BID
	Trandolapril	1-2 mg daily	4 mg daily
ARB	Candesartan	4 mg daily	32 mg daily
	Valsartan	40 mg BID	160 mg BID
BB	Bisoprolol	1.25 mg daily	10 mg daily
	Carvedilol	3.125 mg BID	25 mg BID 50 mg BID (> 85 kg)
	Metoprolol CR/XL	12.5-25 mg daily	200 mg daily [†]
MRA	Spirolonolactone	12.5 mg daily	50 mg daily
	Eplerenone	25 mg daily	50 mg daily
SGLT2 INHIBITOR	Dapagliflozin	10 mg daily	10 mg daily
	Empagliflozin	10 mg daily	10 mg daily*
SINUS NODE INHIBITOR (I₁ INHIBITOR)	Ivabradine (Lancora™)	2.5-5 mg BID	7.5 mg BID
VASODILATOR	Hydralazine	37.5 mg TID	75 mg TID
	Isorbide Dinitrate	20 mg TID	40 mg TID
CARDIAC GLYCOSIDES	Digoxin	0.0625-0.125mg daily	N/A: monitor for toxicity

Note: Drugs and doses may vary and depend upon the clinical scenario.

[†] Not available in Canada. Limited evidence of short-acting metoprolol tartrate in HF.

* Higher doses may be used in people with HF and Type II diabetes for glucose control.

Note: Patients prescribed Entresto™ should never currently be taking an ACE Inhibitor and should not currently be taking an Angiotensin II Receptor Blocker.

Medication Tips

<p>Loop Diuretics Lasix</p>	<ul style="list-style-type: none"> • Avoid taking after 4pm • Recheck renal function, electrolytes within 7 days after a change in dose • Burinex - better GI absorption than Lasix when gut edema (cost of medication needs to be considered)
<p>Metolazone</p>	<ul style="list-style-type: none"> • Means trouble if patient not closely monitored (volume status, kidneys, potassium) • Recheck renal function, electrolytes within 2 days after a change in dose • Consider using a low dose (1.25mg - 2.5mg) sparingly or periodically rather than daily dosing • Most effective when taken 30 mins before the Lasix dose
<p>Titrating ACE Inhibitor/ ARB/MRA</p>	<ul style="list-style-type: none"> • Baseline renal function, potassium • Renal function, Potassium (blood work within 7-10 days of any change in dose) • Asymptomatic low blood pressure is OK
<p>Digoxin</p>	<ul style="list-style-type: none"> • Low dose (trough level <1.0 nmol/L) • Be very careful with elderly, renal impairment • Not first choice of medication- can increase mortality if dose too high • "Caution with digoxin"

<p>Titrating Beta Blocker (BB)</p>	<p>Note:</p> <ul style="list-style-type: none"> • Asymptomatic low blood pressure OK • May experience worse HF symptoms with dose increase (symptoms occur within 1-2 weeks, treat with temporarily increasing diuretic versus decrease BB if possible) • Avoid increasing the dose when: <ul style="list-style-type: none"> • Any extra fluid on board (can't be 'wet' - will feel worse with increase) • Symptomatic low pulse (<60) or low blood pressure • New conduction delays on EKG
<p>Low Blood Pressure</p>	<ul style="list-style-type: none"> • Stagger dose of ACE inhibitor/ARB/ARNI and Beta Blocker (at least 2 hours between medications) • Consider splitting daily dose to BID • Start with low doses and increase slowly (monthly vs every 2 weeks) (reduces side effects) • When trying to titrate ACE inhibitor/ARB/ARNI or Beta Blocker, consider only increasing the PM dose. If tolerated, then increase the AM dose at the next visit. • Use Bisoprolol rather than Carvedilol (more Beta 1 selective) • Give beta blocker with meals (slows absorption) • Consider decreasing diuretic • Consider volume depletion, or other meds (cardiovascular or other) that can contribute to hypotension or orthostatic hypotension (e.g. alpha-blocker)

Entresto™

- Neprilysin inhibitor (Sacubitril) + ARB (Valsartan)
- **Replaces** ACE inhibitor (or ARB) for patients with symptomatic HF despite optimal dose of ACE inhibitor/ARB, BB, and MRA
- When initially prescribing, ensure systolic BP \geq 100 mmHg, eGFR $>$ 30 mL/min, K^+ $<$ 5.2 mmol/L, no history of angioedema, not currently taking an ACE inhibitor or ARB
- Monitor renal function, potassium - as per ACE inhibitor
- Closely monitor blood pressure for symptomatic hypotension
- Never prescribe an ACE inhibitor if taking Entresto™ (angioedema)
- When changing from ACE inhibitor to Entresto™, avoid ACE inhibitor for 36 hours (angioedema)

Dosage

Entresto™ 50mg =
Sacubitril 24mg/ Valsartan 26mg

Entresto™ 100mg =
Sacubitril 49mg/ Valsartan 51mg

Entresto™ 200mg =
Sacubitril 97mg/ Valsartan 103mg

SGLT2 Inhibitors

Practical Tips When Initiating an SGLT2 Inhibitor

Following usual instructions for patients with Type II Diabetes

Additional Considerations for People with HF

May be used for the treatment of heart failure, even if people without type II diabetes

Renal Function

- Additional attention to renal function and electrolytes is needed give the other medications for HF that can impact these values.
- Safe with eGFR $>$ 30 mL/min/1.73m²
- Early 20% decrease in eGFR acceptable. With larger changes in eGFR, evaluate clinically, consider reduction of loop diuretic
- Baseline and periodic monitoring of renal function is recommended, especially if used in chronic kidney disease. Evaluation of renal function and electrolytes within 7-10 days after initiation.
- Acute renal injury rare, except in concert with volume depletion

SGLT2 Inhibitors

Glycemic Control

- Contraindicated for patients with type 1 diabetes
- Collaboration with diabetes team if available
- Concomitant insulin or sulfonurea therapy- consider 25% reduction of each medication. No adjustment if poorly controlled glucose.
- Reinforce glucose monitoring and potential symptoms of diabetic ketoacidosis (DKA)

Volume Control

- Euvolemic- consider reducing loop diuretic 25-50%
- Volume overload- no need to reduce concomitant loop diuretic
- Hypovolemic- do not start until volume depletion corrected
- Reinforce monitoring of daily weights and potential for orthostatic symptoms- especially in the first week of therapy

SGLT2 Inhibitors

Genital and Urinary Infections

- Genital mycotic infections (GMI) are common among females and uncircumcised males
- Reinforce importance of adequate hygiene
- Typically, single dose of fluconazole effective in event of GMI and do not require discontinuation of SGLT2 therapy
- SGLT2 inhibitors may lead to increase urinary frequency but not directly associated with infection

Diabetic Ketoacidosis (DKA)

- As per CDA guidelines, this medication is on the “Sick Day” list (<https://www.diabetes.ca/>)
- High suspicion for DKA required during clinical deterioration. Direct serum anion gap measurement suggested.
- Consider holding dose if acutely ill with limited oral intake
- In addition to other volume-depleting conditions, hold for concomitant infection, trauma, surgery, or other major physiologic stressor.

Additional information on practical approaches for prescribing SGLT2 inhibitors in people with cardiovascular disease from the Canadian Heart Failure Society (CHFS) can be found on the CHFS website. https://heartfailure.ca/sites/default/files/chfs_practical_approach_algorithm_sgl2i_0.pdf

Source: MacDonald et al., CCS/CHFS Heart Failure Guidelines, Can J Cardiology, 2020; Vardeny O & Vaduganathan M. Practical Guide to Prescribing Sodium-Glucose Cotransporter 2 Inhibitors for Cardiologists. JACC 2019

**Lancora™
(Ivabradine)**

- Indicated for people with stable and symptomatic HF, an EF ≤ 35%, in sinus rhythm and with a resting heart rate of ≥ 77 beats per minute who:
 - Cannot tolerate a beta blocker; OR
 - Cannot tolerate the full strength of a beta blocker and continue to have a resting heart rate ≥ 77 beats per minute.
 - For people already taking a beta blocker and continue to have a heart rate ≥ 77 beats per minute, Lancora™ is added to the regimen and does not replace the beta blocker.
- Closely monitor heart rate and rhythm
- Must take medication with food (e.g. breakfast and dinner)
- Cannot take medication with grapefruit juice (>2 fold medication exposure)
- Unlike beta blockers and most calcium channel blockers, Lancora™ does not decrease contractility or reduce blood pressure
- Unlike beta blockers, there is no rebound tachycardia if stopped abruptly

Self-Care Process

Definition	Application
Maintenance	
Adherence to Treatment: <ul style="list-style-type: none"> • Taking medication • Exercise • Dietary advice • Lower risk factors 	What do I need to do to feel well and prevent my heart failure symptoms from getting worse?
Symptom Perception	
Detection of physical change and interpretation of the meaning: <ul style="list-style-type: none"> • Monitoring • Recognition • Interpretation 	What are my early symptoms of heart failure? Are my symptoms today different from my usual pattern?
Management	
Responding to symptoms when they occur: Independent decisions or provider-directed decisions	What do I need to do when my symptoms are changing?

Factors Affecting Self-Care

Domain	Description
Confidence	<p>Self-care confidence is both a moderator and mediator.</p> <p>Strategies to improve patient self-care confidence include:</p> <ul style="list-style-type: none"> • Counseling to recognize benefits and help overcome barriers of self-care, • Reinforcing positive behaviours, • Setting mutual and realistic goals, and • Celebrating successes.
Cognitive Status	<p>Subtle cognitive deficits often go undetected but can interfere with learning and problem solving.</p> <p>Consider screening (ie. MOCA test) for mild cognitive impairment in patients with ongoing challenges with engaging in self-care.</p> <p>Consider underlying subtle delirium if you notice trouble with attention (e.g., infection, recent ETOH, side effects from medications).</p>

Domain	Description
Health Literacy	<p>Patients' ability to understand health and medical issues and directions is related to the clarity of the communication.</p> <p>Health Care Providers need to be sensitive to the individual factors that may impact health literacy as well as the degree of difficulty of the self-care activity requested (e.g. self-titration of diuretics may be too difficult for many patients).</p>
Emotional Status	<p>Consider screening for symptoms of depression/anxiety in patients with ongoing challenges with engaging in self-care.</p> <p>Consider screening for depression using 2 simple questions from the Patient Health Questionnaire-2.</p>

Domain	Description
Learning Environment	<p>Patients need a safe environment (e.g. not punitive) to explore real or potential situations where self-care is difficult.</p> <p>Patients experience many difficulties despite deliberate attempts to make healthy choices. Watch for “unintentional non-adherence”.</p> <p>Common triggers are often tinned soup, processed foods, restaurant food, holiday meals or over-the-counter medications that cause fluid retention (e.g. Ibuprofen).</p> <p>Creative problem solving, cognitive-behavioral strategies and mutual goal setting are necessary.</p>
Learning Over Time	<p>Self-care is a skill and requires practice and learning over time.</p> <p>Let patients know that others have difficulties and encourage them to share concerns and problems.</p> <p>Repeat reinforcement is often necessary in this population.</p>

Domain	Description
Personalization of self-care symptom monitoring and management	<p>Information on ‘how’ to apply self-care information into daily lives is necessary.</p> <p>Help patients work through their experience and strategies for self-care as opposed to reiterating self-care tasks and recommendations.</p> <p>Teach-back technique has been shown to be effective.</p>
Family Caregivers	<p>Caregivers often provide a substantial amount of support for patient self-care activities and need to be seen as partners in the overall care plan. Their contribution, and involvement to self-care cannot be underestimated.</p> <p>Be mindful of caregiver burden.</p>

Advance Care Planning

Although people living with HF can enjoy a good quality of life, it is a progressive condition and having honest discussions around goals-of-care with patients and their caregivers, including advance care planning are a critical part of patient-centred care.

Unlike cancer, the prognosis for HF is difficult to predict. The trajectory of heart failure can have periods of relative stability punctuated by periods of decompensation requiring hospitalization.

Goals-of-care discussions and advance care planning should take place early on in the illness trajectory, when patients are well enough to make informed decisions around their wishes.

Too often, these important discussions do not take place until a patient is severely ill and in hospital. Whenever possible, these discussions should be anticipated and undertaken by the health care team that knows the person and not left for acute care providers in an urgent or crisis situation.

People with HF often have multiple care providers and it is important not to assume that another health care provider will, or has, engaged in these conversations.


Discussions should focus on the values and goals of the individual patient – what they find valuable and important in their lives and what they hope for in the future (e.g. attending an important family event). These conversations are dynamic and evolve over time, as they reflect a person's changing goals and values, and may therefore occur over several visits.*

Care providers are responsible for informing capable patients (or if incapable, the Substitute Decision-Maker) of the expected course of an illness, without conveying false hope, and helping them decide which of the available treatment options are best for them. When making these difficult decisions, clinicians need to support them by verifying their understanding and eliciting their preferences.

*FMPE- The Foundation for Medical Practice Education (2016) Advanced Heart Failure. A Palliative Approach to Care. 24(2). February 2016. www.fmpe.org

Information in this booklet has been guided by the Canadian Cardiovascular Society Heart Failure Guidelines and produced in collaboration with members of the Heart Failure Working Group at CorHealth Ontario. We would also like to acknowledge the contribution of community and primary care nurses who asked key questions and provided valuable feedback to inform the topics addressed in this booklet.

The best cardiac, stroke and vascular care for all Ontarians.

4100 Yonge St., Suite 502,
Toronto, ON, M2P 2B5
T (416) 512-7472 F (416) 512-6425
CorHealthOntario.ca |  @CorHealthON

Last Updated: November 2021