Palliative Care in partnership

RPMG

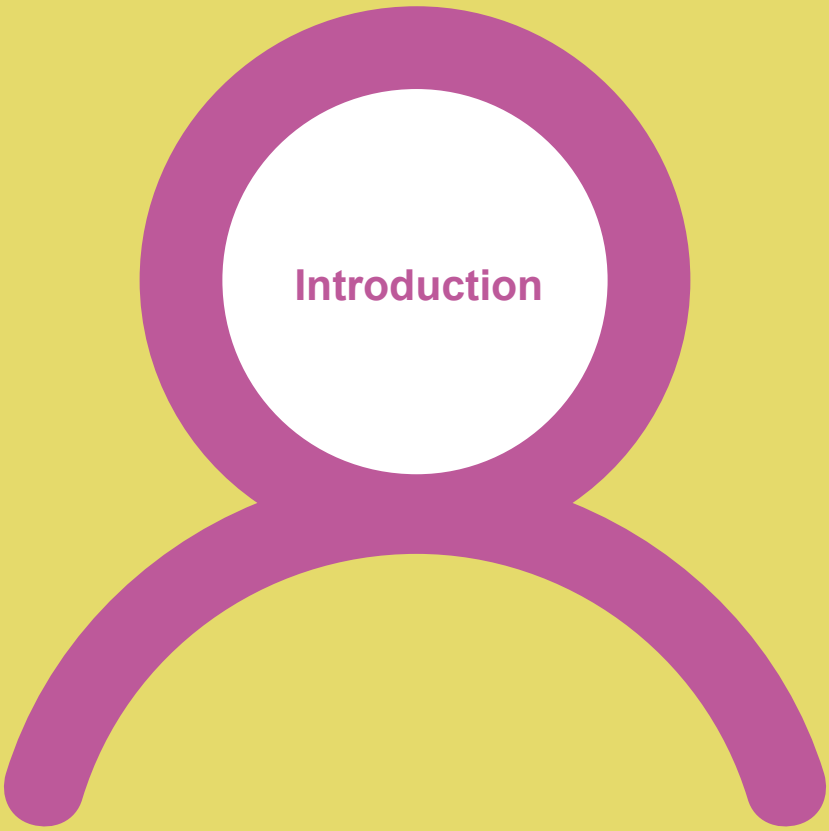
NIPCPG NI Palliative Care Pharmacy Group

British Heart Foundation Northern Ireland

Guidance for the management of symptoms in adults with Heart Failure at the end of life.

This booklet provides guidance to healthcare professionals on managing commonly experienced symptoms for heart failure patients in the last weeks to days of life.

(Updated 2025)



This guidance has been developed for healthcare professionals managing heart failure symptoms when end of life is expected within weeks to days. For these patients it would likely be inappropriate to monitor bloods at this stage of a patient's illness. However due to the trajectory of heart failure it is advised to use clinical judgement to monitor bloods or vital observations should the end of life stage become prolonged or longer than predicted.

When it is recognised that a person may be entering the end of life stage:

- Determine if the patient has an **Implantable Cardioverter Defibrillator (ICD)** and refer to deactivation guidance section below.
- Review and stop any prescribed medication in the last weeks to days of life not providing symptomatic benefit or which may cause harm.
- Discuss and agree any medication changes with the patient and those important to them.
- For community patients, ensure the patient is referred to District Nursing (key worker) and is on the GP's palliative care register.
- If appropriate, ensure onward referral to appropriate palliative care support, hospice care and any other locally available support services.
- Assess and manage the patient's holistic needs. These may be physical, psychological, social, and spiritual or a combination of all of these.
- Ensure anticipatory medicines have been prescribed by the subcutaneous route, see p13

ICD (Implantable Cardioverter Defibrillator): Deactivation Advice

- Cardiac shock therapy at end of life is inappropriate and distressing to both patient and family.
- If the patient has an **Implantable Cardioverter Defibrillator (ICD)** discuss with primary consultant cardiologist or consultant on call in regards to deactivating shock therapy.
- While the need for **ICD** deactivation should be discussed early, before implantation, this should be reviewed when planning for end of life care.
- Planned deactivation of an **ICD** can be facilitated at device review clinic if the patient is well enough to attend hospital, by contacting your local Trust cardiac investigation unit.
- This planned service is available Monday – Friday and during normal working hours. A specific magnet can placed over the device to temporarily deactivate while awaiting support.
- For emergency **ICD** community deactivation, regardless of location and where adequate planning has not occurred, Belfast Health & Social Care Trust Cardiac Investigations Team should be contacted for further advice.

**All emergency end of life community deactivations are carried out by Belfast Health and Social Care Trust within 48 hours.*

RVH device clinic: 028961 51083 (0830-1630)

BCH device clinic: 028950 40403 (0830-1630)

Out of hours CCU RVH: 028906 33229

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The contents of this guidance may differ from other published guidelines, but have been selected to reflect expert opinion, evidence and safety for patients at end of life.

- ✓ Responsibility for the use of these recommendations lies with the healthcare professionals managing each patient.
- ✓ Assess the patient first to exclude potentially reversible and treatable causes of symptoms.
- ✓ Users are advised to monitor patients carefully for side effects and response to treatment.
- ✓ Always start with the lowest dose in the range specified in this guide.
- ✓ Consider non-pharmacological management of palliative symptoms.

Heart Failure Specialist Nursing & Palliative Care Teams

- ✓ Should you require further advice please contact your local Heart Failure service.
- ✓ If the patient is known to the Heart Failure service, the patient should hold contact numbers for the local heart failure team or alternatively contact local HSC Trust.
- ✓ For further palliative care advice please contact the team through the individual hospitals local palliative care team or alternatively contact local hospice in your area.

Abbreviations:

(CSCI) continuous subcutaneous infusion
(DOAC) Direct Oral Anticoagulant
(ICD) Implantable Cardioverter Defibrillator
(TDS) Three times a day
(OD) Once daily
(PO) Oral medicine
(PRN) As required
(QDS) Four times a day
(SC) Subcutaneous
(SL) Sublingual
(IV) Intravenous

Breathlessness

Optimisation of heart failure management may be an appropriate first step and ensure reversible issues are addressed/considered as appropriate, e.g. infection.

Intermittent symptoms

Taking regular Morphine Sulfate or other opioid?

No

- **Tolerating PO medicine**

Prescribe Morphine Sulfate 1mg - 2mg **PO** 2-4 hourly PRN.

If 2 or more doses required, prescribe Morphine Sulfate 2mg **PO** QDS and 2-4 hourly PRN

Dyspnoea associated with anxiety, consider Lorazepam 500 micrograms **SL** 8 hourly PRN

- **Unable to tolerate PO medicine**

Prescribe Morphine Sulfate 1mg-2mg **SC** 4 hourly PRN

If 2 or more doses required in 24 hours consider Morphine Sulfate 5mg via **CSCI** and 1mg-2mg **SC** 4 hourly PRN

Yes

Use the same **PO** or **SC** opioid dose as for managing breakthrough pain

Persistent symptoms

Taking regular Morphine Sulfate or other opioid?

No

- **Tolerating PO medicine**

Prescribe Morphine Sulfate 2mg **PO** QDS and 2-4 hourly PRN

Dyspnoea associated with anxiety, consider Lorazepam 500 micrograms **SL** 8 hourly. If patient tolerating and symptoms persist, consider increasing to 1mg. Alternatively consider Diazepam 2mg-5mg **PO** 4-6 hourly

- **Unable to tolerate PO medicine**

Prescribe Morphine Sulfate 5mg via **CSCI** and 1mg-2mg **SC** 4hrly PRN

If patient is breathless AND anxious, consider:

Midazolam 5mg-10mg via **CSCI** over 24 hours and Midazolam 2mg **SC** PRN 2-4 hourly PRN

Yes

- **Tolerating PO medicine**

Titrate current opioid to patient's individual needs, according to severity of dyspnea.

AND

Prescribe the same **PO** dose as for managing breakthrough pain

- **Unable to tolerate PO medicine**

Prescribe equivalent doses of the same opioid by **SC** syringe pump over 24hrs and titrate to patient's individual needs.

AND

Prescribe the same **SC** opioid dose as for managing breakthrough pain

Consider Oxygen 1-2 litre/min via nasal specs PRN if the patient finds this beneficial for symptom management. However, there may be little benefit in SpO2 greater than 92%
For low doses, oral morphine sulfate is available as both 10mg/5ml oral liquid and 1mg orodispersible tablets

Patients with Mild to Moderate Chronic Kidney Disease **(eGFR 45-60)** are more susceptible to medication side effects and toxicity, therefore:

1. Consider starting all medications at lowest dose and increase dosing frequency.
2. For **Opioids** consider **Oxycodone** as first line and use conversion table on **page 15** for further guidance.
3. **Alfentanil** may be appropriate in worsening renal impairment, please seek specialist advice prior to initiating.

Remember: For patients commencing opioid medications, consider prescribing regular and / or **PRN** anti-emetic and laxative if appropriate. Heart failure patients may already be prone to constipation due to reduced oral intake, immobility and calcium channel blocker or diuretic use.

Breathlessness & Oedema: Diuretic Therapy

Tolerating PO medicine

Consider up titrating oral loop diuretic
(e.g. **Bumetanide** 1mg increments or **Furosemide** 40mg increments)

↓

Xaqua® (Metolazone) 2.5mg **PO** weekly initially, can be increased to 2.5mg on alternate days
or
Consider **Thiazide/ thiazide-like** diuretic (on discussion with Heart Failure Team) such as **Bendroflumethiazide** 2.5mg – 5mg **PO OD**

↓

Consider adding, or if already taking, increasing **Spironolactone** 25mg **PO** alternate days and if tolerated, increase to 25mg **OD** for resistant oedema and breathlessness

It would likely be inappropriate to monitor bloods at this stage of a patient's illness.

Unable to tolerate PO medicines

Patient unable to swallow oral medicines or persistent symptoms.

IV access present and available

Consider **IV Furosemide** bolus using previous **PO** dose as starting dose. When switching **PO** to **IV** a 1:1 conversion is generally used e.g. **Furosemide** 80mg **PO** to **Furosemide** 80mg **IV**

Review after 24 hours and titrate dose if required until symptoms controlled

IV access lost or inappropriate

Consider administering **Furosemide** by **CSCI** syringe pump over 24 hours (**see p14**)

Use previous **PO/IV** 24 hour requirement as starting dose for **CSCI** syringe pump and titrate dose as per clinical need. Use **IV/PO** to **CSCI** conversion of 1:1

(e.g. **Furosemide** 80mg **IV/PO** to **Furosemide** 80mg via **CSCI**)

Review after 24 hours and titrate dose if required until symptoms controlled

Furosemide should **not** be added to or mixed with other drugs in a **CSCI**

Furosemide is normally diluted in a **CSCI** but can be administered undiluted if needed

Always refer to organisational policy and procedures for use and management of **CSCI**.

Note – **PO Bumetanide** 1mg is approximately equivalent to **PO Furosemide** 40mg

Recommended Infusion Sites:

- Upper anterior of arms. Use upper chest cautiously due to risk of pneumothorax
- Sites are often restricted in heart failure patients due to probable oedema.
- Avoid bony prominences and areas where tissue is damaged, thus decreasing absorption.

Nausea

Intermittent: tolerating PO medicine

Consider antiemetic:
Metoclopramide 10mgs 6-8 hourly **PO PRN** max **TDS**

If unable to swallow, tolerate or absorb oral Metoclopramide, consider starting a **CSCI** syringe pump with antiemetic medication

e.g. **Metoclopramide** 30mg/24 hours

Co-prescribe **Levomepromazine** 2.5mg—5mg **SC PRN** 4-6 hourly

*Note **Metoclopramide** and **Cyclizine** should not be co-prescribed together.*

*Where possible **Cyclizine** should be avoided in Heart Failure patients as it can worsen symptoms*

Review every 24 hours

Additional Advice:

Ondansetron may be considered as an alternative to the above medications especially in patients with Parkinson's Disease where **Metoclopramide** and **Levomepromazine**, or **Haloperidol** may cause extrapyramidal side effects.

Ondansetron can be prescribed 4mg **SC** 4-6hrly **PRN** or via **CSCI** 8mg-24mg over 24 hours.

Ondansetron can be very constipating and this should be considered before prescribing.

Anxiety, delirium and agitation

Assess the patient first to exclude potentially reversible and treatable causes such as infection, urinary retention, severe constipation or drug withdrawal (e.g. nicotine).

Intermittent: tolerating PO medicine

Consider
Lorazepam 500micrograms **SL** or **Diazepam** 2mg **PO** PRN **4-6** hourly

Intermittent: unable to take PO medicine

Consider **Midazolam** 2mg-5mg **SC** 2-4 hourly **PRN**

If two or more **PRN** doses required in 24 hours consider prescribing regular

Midazolam 2mg-5mg by **CSCI** over 24 hours

Persistent: tolerating PO medicines

If symptoms persist consider **Diazepam** 2mg-5mg **PO BD** or **TID**

Persistent: Unable to tolerate PO medicines

Consider **Midazolam** 2mg-5mg by **CSCI** over 24 hours
AND Midazolam 2mg-5mg **SC 2 - 4 hourly PRN**

Re-assess regularly. If symptoms persist add total **SC PRN** dose over 24 hours to current syringe pump dose (increase breakthrough dose accordingly)

If poor response to increasing dose of **Midazolam** reassess cause of agitation.

Consider prescribing dose of:

stat Levomepromazine 5mg-15mg **SC**
or
stat Haloperidol 500 micrograms-1mg **SC**

Assess response and if effective add:

Levomepromazine 10mg—25mg or

Haloperidol 1mg-3mg by **CSCI** syringe pump over 24 hours

(Caution: Regular Haloperidol or Levomepromazine are not recommended with Metoclopramide due to increased risk of extrapyramidal side effects)

Pruritus

Consider other treatable causes of itch e.g. dermatitis, uraemia, medication, scabies
Seek specialist advice if necessary

Simple measures to aid relief of itch

- Regular application of a cream based moisturiser can be helpful for pruritus. If the skin is very dry an ointment-based moisturiser may be more effective
- Encourage the patient to use warm tepid water for bathing, if appropriate, and to bath less often.
- Consider adding something soothing to the bath, such as sodium bicarbonate or colloidal oatmeal.
- Avoid soaps, shower gels and bubble baths, which dry skin out by washing away natural oils.
- Avoid irritating fabrics. Where possible, cotton and silk can be cooler and less irritating.

First Line

Apply after washing in the morning and again in the evening;

Use an **emollient of choice** based on patient preference and Formulary choice

Consider **Menthol 2% in Aqueous Cream** (e.g. Dermacool®) for pruritis

Or

Calamine lotion

Avoid if patients skin is broken.

Second Line

Antihistamines, consider

PO Chlorphenamine 4mg **QDS PRN** (max 16mg in 24 hours) and/or

PO Fexofenadine 180mg OD

Often pruritus does not resolve with antihistamine therapy, seek specialist advice

Noisy Respiratory Secretions

- Consider all causes and review the use of intravenous or subcutaneous fluids - decrease or discontinue if appropriate.
- Repositioning can be beneficial. Early use of anti-secretory agents should be considered and can prevent accumulation of new secretions, although has limited effect in clearing those already present.
- Reassure family and carers that although respiratory secretions sound uncomfortable, if the patient is deeply asleep or unconscious, they are most likely not distressed by them. They are present because the patient is not coughing or clearing their throat as they normally would.
- Good mouth care is essential in reducing the sensation of thirst (p14). Use of intravenous or subcutaneous fluids should be reviewed as part of the patient's individualised care plan.

Intermittent

Glycopyrronium 200 micrograms **SC** 4-6 hourly **PRN** (max dose 1.2mg/24 hours)

Persistent

If two or more **PRN** doses are required in 24 hours give stat dose of Glycopyrronium 200 micrograms **SC** and prescribe

Glycopyrronium 600 micrograms by **CSCI** syringe pump over 24 hours

AND

Glycopyrronium 200 micrograms **SC** 4-6 hourly **PRN** for breakthrough symptoms

If symptoms persist, increase total 24 hour dose to maximum of 1.2mg/24 hours

Review after 24 hours.

If symptoms persist consider changing to:

Hyoscine Butylbromide 120mg by **CSCI** syringe pump over 24 hours
or
Hyoscine Hydrobromide 2.4mg* by **CSCI** syringe pump over 24 hours

*__Hyoscine Hydrobromide__ may cause sedation and paradoxical agitation

Cardiac Medication Review Table

Consider stopping all non-essential medications for patients in the last **weeks** to **days** of life:

Seek advice of Heart Failure Team / Cardiology Team if necessary.

In renal or hepatic impairment seek advice for medicine choice & dose adjustment as required.

Consider stopping **Medication with only long term benefit**	**Consider stopping** **Medication with medium term benefit**	**Consider stopping** **Medication with short term benefit**
Statins	ACE Inhibitors Angiotensin Receptors Blockers Angiotensin Receptor / Neprilysin Inhibitor (Entresto®)	Loop & thiazide diuretics
Aspirin	Beta-blockers	Digoxin / Beta-blockers for AF **If symptomatic tachycardia an issue, consider continuing these medications**
Digoxin in patients with sinus rhythm	Spironolactone / Eplenerone **If oedema is present, consider continuing these medications for symptom control**	Patiromer
Anti-anginals e.g. nitrates, nicorandil. **If no recent chest pain or patient hypotensive.**	SGLT2 Inhibitors e.g. Dapagliflozin, Empagliflozin	
	Warfarin/Direct Oral Anticoagulant (DOAC): **Seek advice for mechanical valve or treatment for Pulmonary Embolism.**	
	Clopidogrel, Ticagrelor or other antiplatelet. **Discuss with Cardiology if recent stent insertion due to risk of stent thrombosis**	

For further advice on deprescribing, please consult the STOPPFrail Screening Tool Table 1:

https://pure.qub.ac.uk/portal/files/123615482/ STOPPFrail_Consensus_Validation_Accepted_Manuscript.pdf

Pack size of medicines listed

Oral

Medicine	Strength	Pack size
Bendroflumethiazide	2.5mg tablets	28 tablets
Chlorphenamine	4mg tablets	28 tablets
Diazepam	2mg or 5mg tablets	28 tablets
Furosemide	20mg or 40mg tablets	28 tablets
Levomepromazine	6mg tablets	28 tablets
Lorazepam (Annotate 'Genus®' brand)	1mg tablets	28 tablets
Metoclopramide	10mg tablets	28 tablets
Xaqua® (Metolazone)	5mg tablets	20 tablets
Morphine Sulfate	10mg/5ml oral liquid	100ml
	1mg, 2.5mg, 5mg, 10mg orodispersible tablets	56 tablets
Ondansetron	4mg or 8mg	28 tablets
Spironolactone	25mg or 50mg tablets	28 tablets

Injectable

Medicine	Strength	Pack Size
Furosemide	50mg/5ml or 20mg/2ml injection	10 ampoules
Glycopyrronium	200micrograms/ml injection	10 ampoules
Haloperidol	5mg/ml injection	10 ampoules
Hyoscine Butylbromide	20mg/ml injection	10 ampoules
Hyoscine Hydrobromide	400micrograms/ml injection	10 ampoules
Levomepromazine	25mg/ml injection	10 ampoules
Midazolam	10mg/2ml	10 ampoules
Morphine Sulfate	10mg/ml or 30mg/ml injection	10 ampoules
Oxycodone	10mg/ml, 20mg/2ml, 50mg/ml injection	5 ampoules
Ondansetron	4mg/2ml or 8mg/4ml injection	5 ampoules

Anticipatory Prescribing

Prescribing medicines in anticipation of symptoms that may develop during the last days of life is known as anticipatory prescribing. Having these medicines prescribed and available to the patient can reduce delays in treating symptoms as they develop.

Patients in the last days of life are unlikely to be able to swallow oral medicines and therefore the subcutaneous route is preferred.

When ICD deactivation occurs, ensure anticipatory medicines are available, if they are not already prescribed.

Below is a list of anticipatory medicines that should be considered to treat the common symptoms that may occur during end of life care in heart failure patients.

The drugs prescribed must however be appropriate to the individual patient.

Symptom	Medicine	SC PRN dose	Strength	Pack size
Breathlessness	Morphine Sulfate*	1mg-2mg every 4 hours PRN	10mg/ml injection	10 ampoules
Pain	Morphine Sulfate*	2mg-5mg every 2-4 hours PRN	10mg/ml injection	10 ampoules
Anxiety, delirium & agitation	Midazolam	2mg-5mg every 2-4 hours PRN	10mg/2ml injection	10 ampoules
Noisy respiratory secretions	Glycopyrronium	200micrograms ever 4-6 hours PRN	200micrograms/ ml injection	10 ampoules
Nausea	Metoclopramide	10mg every 6-8 hours PRN (max TDS)	10mg/2ml injection	10 ampoules

* Consider oxycodone in patients with renal impairment.

CSCI Furosemide via Syringe Pump

- Furosemide continuous subcutaneous infusion (CSCI) via syringe pump is an accepted practice in the last days to weeks of life and is safe and effective for people with severe heart failure.
- It may be considered for those who wish to remain at home and are unable to take their oral diuretics or their oral diuretics may now be less effective. It would likely be inappropriate to monitor bloods at this stage of a patient's illness.
- **Starting CSCI Furosemide should be a multi-professional decision involving collaboration between primary and secondary care, with input from specialist teams, together with the GP and district nurse. Help and support should be available e.g. what to do if a patient plateaus or improves. Patients may be able to switch back to oral furosemide.**
- Usually no more than 23-24mL will fit in a syringe for CSCI. This means the maximum Furosemide dose in one syringe pump is 240mg (10mg/ml). If higher doses are required consider an additional syringe pump or a 50ml syringe (if available, check local policy).
- Furosemide can be diluted with sodium chloride 0.9% in a CSCI but may be administered without further diluent if needed. If a diluent is required, sodium chloride 0.9% (10ml amps) should be co-prescribed.
- Furosemide should not be mixed with any other medications in a CSCI or diluted with glucose solutions or other acidic fluids.
- Monitor injection site for signs of reaction and renew as necessary following local organisational policy and procedures for the use and management of CSCI.

Dosing guidance

Use previous PO/IV 24 hour furosemide requirement as starting dose for CSCI syringe pump and titrate dose as per clinical need and use a 1:1 ratio
(e.g. Furosemide 80mg IV or PO to Furosemide 80mg via CSCI)

- If the patient's condition improves, it would be appropriate to switch back to oral furosemide

Simple measures when caring for heart failure patients entering the final weeks to days of life:

- Positioning - the most comfortable position is usually sitting upright with support.
- Elevate the patient's legs.
- Ensure profiling bed available. Keep the room cool.
- Moving air from a fan (hand-held or stationary) or open window as tolerated helps provide psychological relief.
- Careful consideration to oral hygiene as mouth breathing dries the mouth and oxygen (unless humidified) will dry the mouth.
  - Carry out mouth care as often as is necessary to maintain a clean mouth
  - Frequently moisten the mouth with water, ice chips, or artificial saliva products

Opioid Conversion Table

Refer to HSC guidance “Northern Ireland guidelines on converting doses of opioid analgesics for adult use 2023”

Table 1.
Opioid Conversions

PO (Oral) to SC (Subcutaneous)
Oral Morphine to SC Morphine - Divide by 2 Eg. 30mg Oral Morphine = 15mg SC Morphine
Oral Morphine to SC Diamorphine - Divide by 3 Eg. 30mg Oral Morphine = 10mg SC Diamorphine
Oral Oxycodone to SC Oxycodone - Divide by 2 Eg. 10mg Oral Oxycodone = 5mg SC Oxycodone
Oral Morphine to SC Alfentanil - Divide by 30 Eg. 30mg Oral Morphine = 1mg SC Alfentanil Alfentanil may be used in patients with severe renal impairment; seek specialist advice when necessary
SC (Subcutaneous) to SC
SC Morphine to SC Diamorphine – Divide by 1.5 Eg. 15mg SC Morphine = 10mg SC Diamorphine
SC Morphine to SC Oxycodone – Divide by 2 E.g. 20mg SC Morphine = 10mg SC Oxycodone Note this may differ from other available conversions
PO (Oral) to PO
Oral Morphine to Oral Oxycodone - Divide by 2 Eg. 30mg Oral Morphine = 15mg Oral Oxycodone
Oral Codeine / Dihydrocodeine / Tramadol to Oral Morphine - Divide by 10 Eg. 240mg Oral Codeine = 24mg Oral Morphine

Table 2.
Transdermal Patch Conversions

Fentanyl Patch eg. Mezolar®, Durogesic® Replace patch every 3 DAYS	
Fentanyl Patch (micrograms/hr)	**Oral Morphine Dose over 24 hours (mg)**
12	30-59
25	60-89
37	90-119
50	120-149
62	150-179
75	180-239
100	240-299
125	300-359
150	360-419
175	420-479
200	480-539
Buprenorphine Patch eg. Butec®, BuTrans® Replace patch every 7 DAYS	
Patch Strength (micrograms per hr)	**Oral Morphine Dose over 24 hours (mg)**
5	~10 - 12
10	~20 - 24
20	~40 - 48

References

This guidance has been updated from the first edition in 2019 through a collaborative network facilitated by the NI Palliative Care in Partnership Clinical Engagement Group.

The first edition in 2019 utilised expert opinion from Northern Ireland Regional Heart Failure teams, Consultant Cardiologists, Specialist Palliative Care, Clinical Physiology, Primary Care and British Heart Foundation Northern Ireland.

- NICE guideline [NG106] (2018) Chronic heart failure in adults: diagnosis and management Available: https://www.nice.org.uk/guidance/ng106
- NICE guideline [NG31] (2015) Care of dying adults in the last days of life. Available: https://www.nice.org.uk/guidance/ng31
- NI Palliative Care in Partnership (2023) Management of symptoms in adults in the last days of life. Available: https://pcip.hscni.net/download/15/covid-19-info/1557/rpmg-guidance-for-last-days-of-life-2023.pdf
- Subcutaneous furosemide in advanced heart failure: service improvement project. Birch F, Boam E, Parsons S, et al. BMJ Supportive & Palliative Care 2023; 13:112–116.
- Guidance for the Prescribing of Subcutaneous Furosemide by Bolus or Syringe Driver for Heart Failure. NHS Bassetlaw & Doncaster Teaching Hospital 2022. Available at: https://medicinesmanagement.doncasterccg.nhs.uk/wp-content/uploads/2022/05/Guidance-for-the-Prescribing-of-Subcutaneous-Furosemide-by-Bolus-or-Syringe-Driver-for-Heart-Failure.pdf
- Subcutaneous Furosemide in Heart Failure. Pharmacokinetic Characteristics of a Newly Buffered Solution. Sica D, Muntendam P, Myers R, et al. JACC: Basic to Translational Science 2018; 3(1):35-37. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6059009/

Further Reading

- British Society for Heart Failure Supportive Palliative Care in Heart Failure Resources.
  - A Cardiac Supportive Palliative Care Guidance professional resource
  - A What Matters to You? meaningful conversation plan (interactive PDF or printable)
  - A Supportive Palliative Care in Heart Failure patient and carer information booklet

  Available at https://www.bsh.org.uk/patient-information

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design: www.conordiverdesign.com