Practice Problem
- Microsystem assessment completed on unit.
- High readmission rates for CHF and COPD found.
- Gap Assessment done and showed:
  - High preventable readmissions
  - Inconsistency in end of life COPD and CHF care.
  - No focus on Palliative Care.
  - No tool for assessing need for palliative care consults.
  - Misconceptions regarding palliative care.

Clinical Question
Does a structured palliative care program reduce readmission rates in end stage COPD and CHF populations?

Project Description
- A Palliative Consult Tool was developed.
- Team educated on palliative care and use of tool.
- Multidisciplinary team approach was taken. This included:
  - Respiratory, physicians, nursing, care coordination, leadership & palliative care.
  - Palliative care involved with Readmission task force.
  - Demonstrated end of life conversations with team.

Project Evaluation
Program has been well received by the team.

Conclusions
- Interdisciplinary team approach ensures use of palliative proactive tool.
- Discussion about the natural progression of these disease is vital (Köberich, S., Ziehm, J., Farin, E., & Becker, G., 2015).
- Improved patient outcomes and cost effectiveness (lower 30 day readmission rates) demonstrated the importance of a structured palliative care program (Larry Beresford, N., 2013).
- Continued focus on quality, safety and cost.
- Readmission rates has continue to reduce.

Nursing and Healthcare Implications
- Quality of life.
  - Nursing can continue to advocate for optimizing the patient quality of life (Becker, R., 2015).
- Widening the acceptance of palliative care.
  - Interdisciplinary team and bedside nurses can impact the acceptance of palliative care (Yohannes, A. M. (2007).
- Creating a standard of practice
  - This tool decreases the inconsistencies in practice and creates a standard for daily work.

References