autonomy and beneficence, which were not included in PM notes.

Conclusions and Implications. We noted that many of the services provided by clinical ethics are similar to those offered by PM including assistance with goals of care conversations and advice regarding surrogacy. However, use of language such as "ethically permissible" or "legally permissible," accompanied by moral reasoning, may be delivering additional reassurance to medical teams not currently provided by PM. PM clinicians may be able to further assist primary teams by using ethical reasoning in their assessments and recommendations.

Development and Implementation of a Patient-Centered Tool for the Assessment of an In-Patient Palliative Care Team (QI739)

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Objectives

1. Identify primary issues for patients' satisfaction with an inpatient Palliative Care team.
2. Describe areas for improvement for the palliative care team's operation and composition as identified by patients receiving care.
3. Recognize the use of Lean A3 process to improve the administration and refine the content of a survey tool.

Background. Patient feedback is an important part of evidence-based, high value care. We wanted to develop a tool for more rigorous assessment of Palliative Care Services (PCS) at our institution.

Aim Statement. Design and implement a protocol, using a standard Lean A3 problem-solving approach, for collecting inpatient feedback on Palliative Care (PC) team performance.

Methods. Eligible inpatients receiving PCS at our institution were approached in person over a 9-month period, to complete a semi-structured interview regarding their experience of care. The survey tool included Likert scale-based and open-ended questions. We examined characteristics of all patients meeting eligibility criteria and thematically reviewed responses from patient interviews. Lean A3 methods were applied to plan and improve the process.

Results. Of the 74 eligible patients, 21 completed the interview. Major themes included: Felt understood (excellent/good: 95%); communicating plans (excellent/good: 80%), effectively respond to spiritual and religious needs (excellent/good: 75%), team availability (always: 65%), controlling/alleviating symptoms (excellent/good: 80%), sharing information about illness (excellent/good: 70%), likelihood to recommend PCS (very likely: 90%). The open-ended questions identified satisfaction with time spent with and clarification of issues by the PC team. Other common themes included the desire for increased cultural sensitivity and diversity of the PC team. We observed mixed responses about patients' previous or current understanding of PC and the PCS offered.

Conclusions and Implications. Patient's perception of team effort, active listening and strength of relationship with providers has a beneficial impact on the patient's experience of care. Areas for improvement were identified as team availability and sharing of information between providers and patients. Feedback regarding team diversity and previous misunderstandings of PC highlighted the need for continuing public education and re-assessment of the composition of the PC team at our institution. Lean A3 methods were helpful in planning and improving the survey process.

Caution! Unstable Patients Will Collapse Without Warning: Improving Advance Directive Completion for Patients with Chronic Obstructive Pulmonary Disease in an Urban, Safety-Net Hospital (QI740)

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Objectives

1. Recognize the unique challenges to advance care planning discussions in patients with severe pulmonary disease.
2. Identify markers of poor prognosis in pulmonary disease through a novel advance care planning trigger.
3. Evaluate an intervention to increase advance care planning in the outpatient setting with severe pulmonary disease.

Background. Despite recommendations, advanced care planning (ACP) occurs infrequently in patients with COPD. A few studies describe rates of 11-15%, with scant information regarding methods to increase ACP in this population.

Aim Statement. Over six months, to increase advance directive (AD) completion by 10% in patients with COPD requiring outpatient subspecialty care.