Week 7 Discussion: Stakeholders

1. **Identify and examine the organization and/or community stakeholders you anticipate will be a part of the interprofessional team when implementing your future practice change project.**

There are many individuals and groups that would be involved in the change to promote a future practice change project, from the unit to the individual hospital building and finally the entire hospital system that the individual entity is a part of. The primary stakeholder for the foundation is the patient. Patients with heart failure (HF) will be affected by the implementation of the project and are at the heart of the program for ultimate success. Including them and understanding their perspective before implementing a practice change project is essential.

Interprofessional Collaboration (IPC) is a monumental piece of successful practice change in the healthcare system. (Quanbeck, 2019). Different professional groups work together to achieve the result of sustaining the improvement of care through evidenced based practice and support to continue real change. To achieve the change of follow-up support for patients with heart failure many individuals need to be involved. Before the program would even begin, work needs to be done at the system level, coordinating with nurse and physician leaders to discuss the problem of readmission rates for heart failure patients, introduce follow-up interventions and then identify potential barriers together (Quanbeck, 2019). Once the team at the system level has begun the work, then the hospital level needs to develop. At the hospital level, individuals that could be involved in supporting healthcare change for follow-up for patients with heart failure are the Chief Nursing Officer CNO, managers, patient experience liaison, dietitian, social workers, case managers, nurses, pharmacists, heart failure patient educators, entity educators to support nurses and others in the departments and possibly designating a heart failure champion for the units. The incorporation of a dietitian, nurse, nurse educator, and heart failure community outreach nurse could have a long-term impact on positive outcomes for the management of heart failure on multiple levels (McArthur et al., 2021).

Any omissions or gaps in discharge teaching could be linked to deficits in self-care related to heart failure and increased readmission rates, teaching by a nurse educator that specializes in heart failure could decrease the severity and occurrence of these issues. The goals of the treatment of heart failure are to manage signs and symptoms and to delay its progression. Patient teaching is a key part of these goals.

Coordination of care that supports structured follow-up for patients with heart failure could be associated with decreased admissions associated with heart failure exacerbations (Quanbeck, 2019). The community stakeholders would involve the healthcare providers, nurses, case managers, and social workers within the hospital system collaborating with social service providers outside of the hospital as well as wellness clinics in the community and other organizations that touch individual lives (McArthur et al., 2021). Many communities have support groups through senior networks and churches or other local groups. Collaboration between the hospital and these groups can offer support for change after an individual leaves the hospital as well as introduce them to a community that cares about healthy lifestyle changes.