Provide one example, with supporting evidence, of a nurse-driven initiative based on patient feedback received as a result of a service recovery effort.

**Patient Feedback**
In March 2017, the mother of a pediatric patient called the Patient Experience Line to share her concerns with a patient liaison. Her 10-year-old child had been seen at her pediatrician’s office in March 2017 and was diagnosed with flu. The patient’s mother brought her to the North Emergency Department (ED) the next day when her fever could not be controlled. The child looked much better after receiving intravenous fluids, Toradol and Zofran, and she was discharged home to follow up with the primary pediatrician in a few days. Three days after being discharged from the ED, the child was referred to the Children’s Emergency Department (CED) after the primary pediatrician noted changes in her lung sounds.

A second chest x-ray was obtained during the CED encounter, and the patient’s mother was advised that her pneumonia was worse. The patient’s mother was shocked to hear the diagnosis of pneumonia, as that had not been communicated to her. The ED physician from the initial visit had read the chest x-ray as normal, the patient’s mother had never been notified otherwise, and the child had not been treated for pneumonia. The patient’s mother was rightly upset that she had not been given this information and that the correct treatment had not been initiated at the time of the first ED visit.

(Evidence EP17-1, Grievance, Redacted)

**Nurse-driven Initiative**
In early April 2017, Annie Brito, BSN, RN-BC, CCRN, CHPN, Manager of Patient and Family Experience (PFE), was notified of this grievance involving the parent alleging a missed diagnosis from the ED visit. As required by WakeMed’s Complaint/Grievance policy, the investigation is driven and coordinated by a member of PFE. Brito notified Sanjay Premakumar, MD, Quality and Improvement Physician with Wake Emergency Physicians, and Edward Keating, BSN, RN, CPN, Nurse Manager, North ED, of the concerns in April 2017. Keating drove an initiative to determine what happened and to correct the issue to prevent it from arising again. It was found through the investigation that while the preliminary reading of the initial chest x-ray was negative, the final reading from the radiologist did indicate pneumonia.

Two days later in April 2017, Keating engaged the following team members to analyze the process for follow-up calls regarding test results that are received after ED patients are discharged: Brinda Rangasamy, RN, Case Manager; Cheryl Kilbourne, MSN, RN, Director of Nursing Services, North; and Clinical Nurse Susan Harris, RN, ED Discharge and Follow-Up Nurse. When an after-discharge result is received, the follow-up RN is sent a message that is designated by Epic for the appropriate facility. The nurses continually check all messages in their inboxes throughout the day, seven days a week. Once notified of a significant result, the follow-up RN takes the message to the ED for
immediate follow-up with the physician on duty. The RN obtains a physician order if necessary and notifies the patient if there is a change in the plan of care or further care required. (Evidence EP17-2, Keating Email)

Keating coordinated communication with the team and engaged Vincent Miliano, RN, Systems Analyst III, to get perspective on the issue as it involves the electronic medical record (EMR). Miliano learned through his analysis and communication that the report on the child’s chest x-ray from the radiologist was entered in the EMR within seconds of the patient’s discharge being completed. Results that are received after discharge are automatically sent to the follow-up RN’s inbox for further attention. Since the reading from the radiologist came in the same minute as the discharge, Epic did not recognize the result as arriving after discharge and therefore did not send the alert to the follow-up nurse. The system glitch that Miliano identified occurred when the patient’s test results were received in the same minute as the patient’s discharge, meaning the notification of an outstanding test result was not sent automatically to the follow-up RN’s patient call list. This issue with the automatic trigger for the follow-up RN to call failing to deploy revealed an opportunity for improvement.

Miliano identified the glitch and remedied it with Epic. (Evidence EP17-3, Miliano Email) Prior to this event, results received after discharge were the trigger for sending an alert to the follow-up RN. The process change that was implemented was to send the trigger for receipt of results after disposition (when the ED physician writes the discharge note) rather than after discharge (when the patient physically leaves the department).

As a result of this investigation that began with the patient’s feedback, a large-scale upgrade was implemented to prevent a similar situation from occurring again at WakeMed or any other health care system that uses Epic. Epic shared that the vulnerability that impacted the patient’s care at WakeMed had the potential to impact patient care in 47 health care systems that use the same version of Epic. (Evidence EP17-4, ASAP Results Issue)

**Service Recovery Effort**

In keeping with the culture of transparency, the mother was communicated with during the investigation through a series of phone calls from Premakumar and Keating and a letter from Brito acknowledging her concerns, offering sincere apologies and asking clarifying questions. Keating and Brito wanted her to know that the ED physicians, members of Risk Management, follow-up nurses and IT specialists were working on a billing adjustment and determining the root cause of the system failure in follow-up. In May 2017, Brito sent the patient’s mother a final letter communicating the components of the investigation; the findings from the interprofessional team, including the ED physicians and radiologist group; system corrections made as a result of the event; and service recovery in billing from the facility. (Evidence EP17-4 Follow-up Letter)