

# Maryland Facilities Share Progress on Keeping Patients Safe

The Maryland Patient Safety Center 2009 *Directory of Solutions*  
A Compilation of Innovative Patient Safety Initiatives

April 2009

## Overview

Healthcare providers around the region are engaged in numerous activities that continually improve quality and patient safety. Each year, the **Maryland Patient Safety Center (MPSC)** collects and publishes information about the quality and patient safety initiatives taking place in Maryland and across the region. The *Directory of Solutions*, a compilation of these innovative projects, is a key resource for providers in the region. The 2009 edition of the ***Directory of Solutions*** was distributed in April at the Fifth Annual MPSC Patient Safety Conference, which was attended by more than 1,500 healthcare professionals.

## About the *Directory of Solutions*

The 2009 *Directory of Solutions* showcases 102 patient safety initiatives taking place at 33 healthcare facilities in Maryland and Delaware. Each was submitted to MPSC by healthcare providers as a way to share best practices with their colleagues. This represents a remarkable willingness to break down the barriers between facilities and engage in collaborative improvement with the goal of providing safety to all patients.

The *Directory* includes innovative programs designed to:

- Improve communication and teamwork;
- Build a strong culture of safety;
- Educate all stakeholders about techniques, processes, and systems for quality improvement and patient safety;
- Enhance safety in the emergency department, intensive care unit, laboratory, labor and delivery, and operating room;
- Effectively use event reporting to identify areas for improvement;
- Prevent falls, infections, pressure ulcers, and medication errors;
- Involve patients as partners in patient safety;
- Redesign processes to bolster safety; and
- Engage the healthcare workforce in initiatives for safety improvement.

Nine of the initiatives from the *Directory* were selected as "Best Solutions" and were presented at the MPSC Patient Safety Conference. The following are examples of the Best Solutions.



A collaboration between the  
Maryland Hospital Association and  
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### Preventing and Reducing Ventilator Associated Pneumonia (VAP)

**Anne Arundel Medical Center** established a collaborative, multidisciplinary team approach for addressing infections in the intensive care unit (ICU). After identifying and implementing a series of interventions, the VAP rate dropped from 20.1 per 1,000 ventilator days to 2.6 per 1,000 ventilator days and the Medical Center had several months of zero cases of ventilator associated pneumonia.

### Eliminating Blood Stream Infections in the Surgical Intensive Care Unit

Through infection control surveillance and careful data collection, the **Johns Hopkins Bayview Medical Center** identified that its blood stream infection (BSI) rate was 3.29 infections per 1,000 central line days in 2007. To address this issue, Bayview implemented a series of BSI best practices and evidence-based interventions. As a result of these actions, the Medical Center had zero central line blood stream infections and had gone for 14 months without a single BSI.

### Improving Safety and Satisfaction in the Emergency Department (ED)

Concerns about patient safety, time delays, and backlogs of patients in the ED led the **St. Joseph Medical Center** to apply Lean Process Improvement Principles to analyze the issues and make improvements. Halfway through the 100-day project, the St. Joseph team had reduced by 90 percent the length of triage process time for “walk in” patients, reduced complaints by 26 percent, reduced bed placement cycle time by 75 percent, and decreased the number of diversions from its ED.

### Surviving Sepsis Campaign

After identifying that sepsis infections consistently had one of the highest mortality rates, **Shore Health System** and **University of Maryland Health System** (UMMS) implemented the national Surviving Sepsis Campaign guidelines then spread their improvements to other facilities within UMMS. To date, Shore has met its goal of reducing mortality, which translates into saving an estimated 20 lives each year—and the project continues to save even more lives.

### Enhancing Communication and Teamwork

Based on the findings of root cause analyses, incident reporting data, and patient safety survey results, **Shady Grove Adventist Hospital** leadership made improving communication and fostering teamwork among healthcare providers a priority. Beginning in 2006, the Hospital implemented the TeamSTEPPS training program to strengthen these priority areas. From 2006 to 2008, Shady Grove noted reductions in the number of adverse events and malpractice claims expense, improvement in employee satisfaction, and reductions in staff turnover and agency use.

### Strengthening Surgical Workflow to Improve Care

To improve efficiency and standards for patient care delivery in the operating room, **Atlantic General Hospital** implemented a strategic action plan, Surgical Workflow Improvement Process to Excel (SWIPE). Since implementation in 2007, Atlantic General has improved and maintained patient and physician satisfaction, improved and maintained compliance with national Hospital Quality Measures, increased the time RNs spend on care as opposed to paperwork, and improved communication and collaboration among physicians, nurses, and all hospital departments.

### Enhancing the Culture of Safety

Recognizing that improving systems and processes is essential to reduce harm, **Anne Arundel Medical Center's** Patient Safety Committee designed an organization-wide program to promote, encourage, and reward staff for reporting near misses. Among the goals of the program were to foster a culture where staff are safety conscious, freely report near misses and adverse events, and information and tools are available to prevent or reduce the probability of patient harm. After implementing a new program, the "Good Catch Club," the number of near misses reported through the Medical Center's 4PTS Hotline has increased—with 29 different units/departments identifying 249 near misses, or "good catches."

### Reducing Labor and Delivery Triage Process Time

**Johns Hopkins Bayview Medical Center** found that the number of births was increasing while the available space to care for mothers and babies stayed the same. To increase efficiency and decrease length of stay in the triage area, the Medical Center employed the Lean Sigma process to identify new efficiencies in the triage process. After implementing this initiative, the average triage length of stay went down 35 minutes per visit even though the triage census—the number of patients triaged each day—increased from nine to 16 patients, an estimated 78 percent.

Remarkably, each year MPSC receives more and more submissions to the *Directory of Solutions*, with almost a twofold increase in submissions from 2008 to 2009. This represents strong interest in the *Solutions* approach, shows a willingness to share, and, most importantly, demonstrates a focused and growing commitment to patient safety efforts among providers in the region.

Solutions submissions, including detailed descriptions and facility contact information, are available on the MPSC Website, [www.marylandpatientsafety.org](http://www.marylandpatientsafety.org).