Message from the President & CEO

As winter draws to a close, the team at the Maryland Patient Safety Center is excited to bring a year's worth of planning and hard work to fruition on behalf of our members when we host the 9th Annual Maryland Patient Safety Conference on April 5, 2013 at the Baltimore Convention Center. We are confident this year's event will be a crowd pleaser in terms of the diverse cross section of educational offerings and the meaningful theme of **Walk the Talk: The Consequence of Everyone as a Leader**.

We are proud to be welcoming former New York City Mayor Rudolph Giuliani and President of the Joint Commission, Mark R. Chassin, to Baltimore as our keynote speakers. Their commitment to the event has created a definite buzz in the healthcare and business communities in Maryland and will help further raise the profile of the event.

Response to the conference thus far has been outstanding, but it is not too late to be a part of it by registering as an attendee or to support the event as a sponsor. More details on the conference are included in this newsletter.

In addition to the buildup to the annual conference, we are forging ahead with a number of new initiatives in 2013 in response to the needs of our members and to keep us on the cutting edge of patient safety on a national level. Director of Operations, Bonnie DiPietro, offers more details in an insightful Q&A in this issue.

We are also excited to be rolling out our new "Get Centered" campaign, aimed at providing tangible reminders to our members and employees of our member institutions about the vital importance of staying focused on patient safety at all times. The initiative will also help raise awareness of the Maryland Patient Safety Center, including our mission and the practical resources we provide to build a safer health care system.

Look for more details at the conference in April. We look forward to seeing you there!

Sincerely,

Robert Imhoff
President & CEO

MARYLAND Patient Safety CENTER

Making healthcare in Maryland the safest in the nation

To find out more about Maryland Patient Safety Center, please contact Kathy Batz at 410-540-5040 or kathyb@marylandpatientsafety.org

www.MarylandPatientSafety.org
6820 Deerpath Road
Elkridge, MD 21075
410.540.9210

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Spring 2013

Maryland Patient Safety Center

Keeping Patients Safe

The Countdown is on...

to the 9th Annual Maryland Patient Safety Conference

Registration Closes March 22, 2013

"America's Mayor," Rudy Giuliani, and President of the Joint Commission, Dr. Mark R. Chassin, to Headline Maryland Patient Safety Conference

Health care industry leaders from throughout the region are set to converge on Baltimore on April 5, 2013 for one of the most anticipated patient safety events in years.

Former New York City Mayor Rudolph Giuliani will serve as opening keynote speaker and President of the Joint Commission, Mark R. Chassin, MD, FACP, MPP, MPH will offer the closing keynote address.

In addition to the addresses by these high profile leaders, the 9th Annual Maryland Patient Safety Conference will feature a variety of presentations and panel discussions covering a wide variety of patient safety issues.

For full registration details and information on timing and topics covered, visit our newly designed website, *www.marylandpatientsafety.org*.

Update on Educational Initiatives and What's Ahead in 2013

Director of Operations, Bonnie DiPietro, offers some exciting updates on our existing patient safety initiatives and provides a sneak peak about what lies ahead in 2013 in this Q&A.

Q: The center's Hand Hygiene initiative has become an important and impactful program. What do members need to know about it?

Bonnie: The statewide initiative is aimed at the prevention of healthcare-associated infections in hospitals. Our goal is to achieve a better than 90 percent hand hygiene compliance rate among Maryland acute care hospitals.

Q: What is the current level of participation across the state?

Bonnie: A lot of work in the past year has focused on increasing the participation in the Hand Hygiene initiative by acute care facilities. We currently have participation by 44 out of 46 acute care hospitals throughout the state. We have also been focusing on the data component—making sure that participants are reporting properly and complying with the methodology. Currently, over 90% of the units at those hospitals are reporting the required volume of data.

We feel that we have made significant strides with regard to the data and reaching a 90% compliance rate as we are now at approximately at 83%.

In 2014, we are planning on expanding the initiative beyond hospitals and into other facilities such as long-term care and community health centers.

Q: What are the major barriers to compliance with hand washing?

Bonnie: First and foremost, our data shows that 83% of the time clinicians are engaging in hand hygiene practices. The remaining 15% or so I feel is due to the competing demands of the clinician in that they are tending to so many tasks that hand hygiene is unintentionally omitted.

Q: What recent advancements have been made to the SAFE from FALLS initiative?

Bonnie: We have done a lot of work this year on increasing the participation in the hospitals but also participation in long-term care facilities. We count 44 long-term care facilities that are participating in the collaborative and 15 home health agencies. We have seen a decrease in the number of falls with injury as a result of the efforts of this collaborative; however the rates of falls have not changed significantly. While the rate in hospitals is at about 3 per thousand patient days, which is below the national rate of 4.6, we still see opportunity for improvement.

Q: What other things are you looking at to reduce the rates of falls?

Bonnie: We are working toward implementing prevention practices for patients identified to be at risk for a fall. Much research has been done to examine the reasons people fall in hospitals. For instance, people are often weak when they come to the hospital, they are on medications, they are in a foreign environment, etc. and we are looking to see what can be done to mitigate some of those factors.

Q: Are there any new educational initiatives that we can look forward to this year?

Bonnie: Caring for the Caregiver is an initiative we hope to launch this year that focuses on addressing factors that affect a healthcare worker's ability to safely carry out their responsibilities. We will examine issues such as worker fatigue, the impaired practitioner and the concept of the "second victim." The second victim refers to a caregiver who has made an error that resulted or may have resulted in patient harm. This is an emerging area in the patient safety arena and we are proud to be working on the cutting edge.

Maryland Patient Safety Center Participation Pays Dividends

The Maryland Patient Safety Center values all of our members and participating organizations. Beyond building a safer health care system, our goal is to foster long-term participation and continued growth of the organization.

We hope you view your membership as a terrific value that offers a number of tangible, practical benefits to your organization. We've listed 10 great reasons for membership below.

1 Greater Efficiency: Providers can share risk information to accelerate identification of patient safety trends and accelerate the speed with which solutions can be identified and best practices adopted.

2 Health Reform Requirement: All hospitals over 50 beds must maintain a Patient Safety Evaluation System by 2015 to participate in the state insurance exchanges.

3 Prevention: By sharing quality data, a PSO will be able to identify patterns that could suggest underlying or systemic causes of patient risks and hazards to prevent their future occurrence.

4 Peer Review Protections: All licensed providers are covered by federal peer review protections. Peer review statutes in 14 states provide protections for pharmacy activities and 9 states for nursing activities.

5 Benchmarking: Comparing regional and nationwide performance with other providers.

6 Integrated Care: Share protected information among unrelated providers.

7 Significant Cost Savings: Significant savings in reduced healthcare costs and reduced malpractice operational costs.

8 Enhanced Patient and Consumer Confidence: patients and the general public recognize and appreciate when institutions make safety a priority.

9 Learning: By facilitating a shared-learning approach, hospitals and providers can learn from each other, make faster improvements and reduce the cost of learning.

10 Malpractice Reform: Such as the Patient Safety and Quality Improvement Act (PSQIA)

2013 Award Winners Announced

The Maryland Patient Safety Center is proud to announce that MedStar Franklin Square Medical Center is the winner of our 2013 Distinguished Achievement in Patient Safety Innovation Award and Western Maryland Health System is the recipient of the 2013 Minogue Award for Patient Safety Innovation.

While both organizations will be formally honored at our annual conference in April, we wanted to share more details about the innovative programs each health system developed in response to critical patient safety challenges.

2013 Minogue Award for Patient Safety Innovation

Western Maryland Health System
D2B: A Rural Community's Story–Shifting Cath Lab Activation for Acute MI to EMS "First Responders"

Western Maryland Health System (WHMS) is one of the primary providers of healthcare in a rural part of the state. One of the organization's primary goals is to ensure that cardiac services meet the established standards of care. WMHS found it imperative to make a process change after carefully considering why ST-Elevated Myocardial Infarction (STEMI) patients arriving by EMS did not have lower Door-to-Balloon (D2B) times in comparison to patients arriving by private transportation.

The team at WMHS identified several major obstacles they had to overcome to improve D2B times. The rural EMS region where WMHS operations contains many geographical barriers and communication "dead zones," which can significantly impact the success of transmitted ECGs. Additionally, an Emergency Department physician had to first contact the cardiologist by faxing the 12-lead ECG they received from the field. The cardiologist then made the subsequent decision on whether to activate the cath lab staff. This made for an unnecessarily lengthy process for patient for whom every second is critical. The team reviewed the national guidelines and all relevant literature, including reams of relevant data and statistics, in order to identify multiple opportunities for improvement in the current practice.

From there, they developed and executed a new process: if a STEMI is identified with the use of an ECG by an ALS field provider, the provider will request "Field Activation" of the cath lab team, regardless of their ability to successfully transmit the ECG to the receiving facility. This shifts the decision away from the ED physician and cardiologist, creating a more rapid response. The team rigorously planned the change by educating all ALS paramedic providers and requiring them to complete a 12-lead ECG Interpretation course. Additionally, all hospital disciplines involved in the implementation of "Field Activation" received the appropriate education.

Implementation of this practice change included: adding an ECG system (Rosetta) onto each ALS ambulance in the region while training the ALS providers on its use; training qualified EMTs on the process of obtaining and transmitting ECGs (data reported that 80 percent of calls were initially handled by EMTs); presenting available data, outcomes and proposed solutions at departmental meetings in order to track the program's success.

The "Field Activation" gained support from all stakeholders and officially began on June 21, 2010.

Measureable Outcomes:
Since implementation of the new system, the resulting data shows measureable and positive progress:

- 41.6 percent of WMHS patients presenting with STEMI arrival by EMS in 2010 to 2012 had a mean D2B time of 55.4 minutes, compared to 78.0 minutes for EMS without Field Activation.
- After the move to the new system, the implementation of Field Activation for STEMI patients has stabilized D2B times to a mean of 71.8 minutes. This data takes all STEMI patients into account and this includes both EMS and private vehicle arrivals. Any delays that were brought about as a result of a patient driven delay (e.g., VT/VF/Intubation) were removed from the data sample.

As WMHS continues to benchmark compliance with evidence-based standards and to achieve positive patient outcomes, each individual case is analyzed and studied in order to identify any possible opportunities for improvement.

The Mission and Core Values of WMHS were the driving force behind taking on this challenge and finding a workable solution.
The primary outcome of reducing D2B time for STEMI patients was met and has even exceeded the nationally-established standards. Sharing these results throughout the organization has created a working knowledge of the goals and expected outcomes of all levels of hospital staff, including the physicians and executive leaders.

As a result of a heightened level of awareness, along with the ongoing commitment and dedication to this initiative, WMHS was able to allocate capital funds to purchase an updated system for local EMS providers. This will allow for continued improvement in the reliability of 12-lead ECG transmission from the field to the hospital facility, and ultimately, a higher quality of patient-centered care for the population served by Western Maryland Health System.

2013 Distinguished Achievement in Patient Safety Innovation

MedStar Franklin Square Medical Center
The Golden Hour: Neonatal Resuscitation During the First Hour of Life

MedStar Franklin Square Medical Center was not satisfied with infant morbidity and mortality rates in their NICU. They wanted to improve morbidity and decrease mortality in premature infants by improving the care provided during the first hour of life relative to regional and national benchmarks.

A multidisciplinary team utilized research and evidence based practice to standardize the approach to neonatal resuscitation for premature infants.

The group recognized that during resuscitation, there are consequences to all key elements of the process—ventilation, oxygen, thermoregulation, respiratory distress and infection. By standardizing the approaches to initiating these elements, the team was able to meet individual outcomes for all key elements of the resuscitation process.

A debrief tool was developed to identify barriers, improve autonomy and accountability. Barriers that were identified by the debrief tool were examined and discussed with leadership until workable solutions were created. Ultimately, a Golden Hour Tool was developed by the group to use as a timetable for managing neonatal resuscitation during the first hour of life according to professional role.

Nursing collaborated with medicine, respiratory, unit secretaries, obstetricians and labor and delivery direct-care nurses to develop a scripted approach to neonatal resuscitation. After implementation, the team evaluated the progress by comparing results against regional and national benchmarks. Initial results revealed compliance with maintaining oxygen saturation in the 88-95% range, surfactant administration within one hour and antibiotics within one hour. Minimal change in chronic lung disease, morbidity or mortality were noted in Phase 1 of implementation. The group re-convened and continued to identify barriers and solutions to achieving their goals for chronic lung disease, morbidity and mortality.

Measureable Outcomes:

- Implementation of the Golden Hour Tool during resuscitation minimized the short term consequences in the first hour of life.
- The outcome of the implementation revealed a decrease in MedStar Franklin Square Medical Center's rate of mortality or morbidity due to prematurity from 64.3 percent in 2009 to 38.9 percent in 2011, which is well below the 47.8 percent VON benchmark.
- Additionally the percent of infants less than 32 weeks with temperatures greater than 36° C increased from 95 percent in 2009 to 100 percent in 2011, which is well above the 72 percent VON benchmark.
- Infants needing oxygen at 36 weeks dropped from 48.3 percent in 2009 to 16.7 percent in 2011, well below the VON benchmark of 25 percent.
- Infants receiving IV antibiotics within one hour rose from 28 percent in 2009 to 88 percent in 2011, well above the 66 percent benchmark.
- Infants receiving surfactant within one hour rose from 17 percent in 2009 to 100 percent in 2011, well above the 90 percent benchmark from the neonatal collaborative.

This new initiative is now firmly embedded into the NICU culture at MedStar Franklin Square. Debriefing sessions continue to identify barriers to program implementation and solutions are developed in response.

Hospital leadership was crucial in breaking down barriers identified by the interdisciplinary team at the outset of the process. Their passion and dedication to finding solutions to this important issue served to motivate and inspire the entire team. Identification of the team players from every discipline played a role in the success of the program. Every discipline needs to be aware of the data and best practices for providing resuscitative care to neonates. Promoting interdisciplinary partnerships and establishing good communication skills helped the team to use the data to improve care. The outcomes of this initiative speaks to the high quality of care MedStar Franklin Square provides.