Transparency and Communication in Focus at 14th Annual Patient Safety Conference

Approximately 1,500 healthcare professionals from throughout the region gathered at the Hilton Baltimore on Friday, April 13, 2018 for the 14th Annual Maryland Patient Safety Conference.

The daylong event carried the theme of Transparency and Communication: The Gateway to Patient Safety and featured national experts and local organizations sharing best practices.

James R. Rost, MD, Chair of the Maryland Patient Safety Center Board of Directors, welcomed attendees and kicked off the day with opening remarks highlighting recent accomplishments of the center and initiatives slated for the coming year. He reiterated the Maryland Patient Safety Center’s goal of making healthcare in Maryland the safest in the nation.

Interactive Opening Keynote
Opening keynote speaker Rosemary Gibson, Senior Advisor for The Hastings Center, shared an engaging presentation that highlighted the evolution of patient safety over the past decade or more. Interestingly, Rosemary was invited by the Maryland Patient Safety Center’s first President and Executive Director, William Minogue, MD, FACP, to present at one of the very first conferences the center ever hosted. She commented on how far the field has come and how large the crowd was for this year’s event relative to the early years of the conference.

Rosemary also described her journey in writing her book, The Wall of Silence: The Untold Story of Medical Mistakes that Kill and Injure Millions of Americans. She disclosed how initially, she was intimidated and even scared to reveal the findings of her research for the book, even with close friends and associates. She was worried about the prospective widespread ramifications the information may have on the medical field.

In retrospect, she drove home an important message with the attendees that is applicable for all healthcare professionals.

“The most important lesson I learned from releasing my book was how important it is to have the courage to speak up and share your mistakes and knowledge with others,” she said.

During her interactive presentation, Rosemary asked for feedback from the audience on a number of issues, including what are the biggest advancements in patient safety that attendees have experienced during their career.

Trina Leake, an Inpatient Pharmacy Supervisor at St. Agnes Hospital said, “Measuring and reporting on errors is so vital because we realize mistakes happen, but we need to document what happened and share what we learn. We need to be comfortable growing and learning from our own mistakes as well as the mistakes and best practices of others.”

Barry Aaron, MD, a Urologist at Shady Grove Medical Center said, “Our evaluation of best practices and practices based on science instead of habit have led to major improvements in patient safety.”

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**Education and Collaboration Throughout the Day**

Following Rosemary’s presentation, attendees took part in a series of sessions covering a vast range of patient safety issues, ranging from intra-facility patient transfers and reducing opioid prescribing to patient communication and safety in end of life care.

Conference attendees came away feeling inspired and remarked on what an important resource the conference is for team members at all levels of a healthcare organization. “It is amazing to see the collaboration with different hospitals and the transparent approach to healthcare is really helping to move the field forward,” said Jennifer Grover, Physician Assistant at Anne Arundel Medical Center. “The frequency and high level of collaboration across the state and throughout the region is great.”

**Touching Closing Session**

Ridley Barron, a patient advocate with Ridley Barron Ministries, offered the closing keynote entitled *Every 1/2 Second Counts*. Ridley shared the tragic story of how an auto accident took the life of his wife and badly injured his 17 month old son Josh. His son initially survived the accident, but later died in the hospital due to a medication error. Ridley never sued the hospital and interacted with the pharmacist who made the error and told her he forgave her.

Ridley’s message didn’t dwell on the negative, but rather focused on how important and challenging the work on the front lines of healthcare is and how every 1/2 second counts and requires complete focus. It has been 15 years since Ridley lost his wife and son, but he is still inspiring others by sharing his story with a focus on helping healthcare providers develop a culture that doesn’t punish mistakes, but promotes transparency and openness for constant improvement in patient safety.

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**Minogue Award Winners**

At the conference, the University of Maryland Upper Chesapeake Medical Center was honored as the recipient of the 2018 Minogue Award for Patient Safety Innovation. Their award winning program was entitled S.T.A.R.T. with the patient: A safe transition and risk assessment tool. Anne Arundel Medical Center has been named the recipient of the Distinguished Achievement in Patient Safety Innovation Award for their program entitled Reducing opioid prescribing: A health system responds to an epidemic.

Eight other facilities were named Circle of Honor winners.

1. Calvert Health Medical Center: Promoting the appropriate use of opioids: A community hospital’s response to a national health emergency
2. The Johns Hopkins Hospital: Hopkins NINJA: Nephrotoxic injury negated by just-in-time action
3. Greater Baltimore Medical Center: Focused problem solving through lean daily management
4. Sinai Hospital of Baltimore: Drawing placental blood for admission labs in very low birth weight infants: A process change that reduces early transfusions
5. Sinai Hospital of Baltimore: Improved outcomes with perioperative glucose management
6. Northwest Hospital, LifeBridge Health System: Northwest Hospital’s journey towards high reliability: What does it take?
7. U of MD Upper Chesapeake Medical Center: An orthopedics approach to population health management —development of a geriatric hip fracture program
8. U of MD Upper Chesapeake Medical Center: Stop snoring with a bang! Reducing postoperative complications by screening patients for obstructive sleep apnea (OSA) risk factors

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**American Journal of Infection Control Shares Clean Collaborative’s Success in Decreasing C-diff Rates**

The Maryland Patient Safety Center was honored to have the success of our Clean Collaborative touted in the May 2018 issue of the *American Journal of Infection Control*. Key findings included the fact that healthcare facilities participating in the Clean Collaborative achieved a 14.2% decrease in *Clostridium difficile* (C-diff) rates compared to just a 5.9% decrease among non-participating facilities.

Participating facilities implemented engineering controls and behavioral changes as a result of the Collaborative educational process.

The Clean Collaborative was founded upon the hypothesis that proper cleaning and disinfection of facility-wide, high-touch areas and quantifiable validation of such methods will assist healthcare environmental service managers and infection preventionists in reducing healthcare associated infections (HAIs).

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**In Memoriam**

The board of directors and staff of the Maryland Patient Safety Center extend their condolences to the family, friends and colleagues of Dr. Lawrence Scott Linder, a former President and CEO of University of Maryland Community Medical Group and former director of emergency medicine at the University of Maryland Baltimore-Washington Medical Center and longtime board member of the MPSC. Dr. Linder passed away suddenly on May 1, 2018. Dr. Linder was a passionate advocate for patient safety and we are grateful he lent his experience, intellect and great sense of humor to his work as a board member.
A recent study indicated that 80% of nurses do not feel completely safe in the workplace. Other frontline medical employees reported similar perceptions.

Providing support to healthcare workers who are victims of workplace violence is an important component of the Maryland Patient Safety Center’s Caring for the Caregiver program which was developed in collaboration with the Armstrong Institute’s RISE team at Johns Hopkins Hospital.

The Armstrong Institute will be presenting details of our Caring for the Caregiver program at the Maryland Hospital Association’s summit on June 28 - Safe Harbors: Protecting Providers and Patients.

In addition, the Center took part in the American Hospital Association’s Hospitals Against Violence initiative #HAVhope Day of Awareness on social media on June 8, submitting photos showing our organization’s commitment to combating violence.

Making progress on this issue will take time and a coordinated effort on many fronts. The Center looks forward to doing our part and partnering with like-minded organizations on a local and national level.
The 14th installment of our Annual Patient Safety Conference was our largest and most successful yet, despite being held on Friday the 13th! The excitement and energy in the main ballroom at the Hilton was amazing and we are grateful to everyone who helped make the event possible, including all of our sponsors, staff members, our board members and of course our presenters and attendees representing a wide range of professions to include physicians, nurses, respiratory therapists, risk managers and safety and quality professionals, to name but a few.

The success of the conference is representative of the continued increase in participation we are seeing at the Maryland Patient Safety Center in nearly all aspects of our programming:

• Over the last year, the majority of our training classes have been at or near capacity.
• Attendance at our fall medication safety conference more than doubled from last year to over 400 participants.
• Our patient safety officer forums and PSO Safe Table continue to be extremely well attended and valued forums for the free exchange of patient safety and quality issues from the majority of Maryland hospitals.
• Our Perinatal / Neonatal quality collaborative enjoys participation from all 32 birthing hospitals. 30,445 education modules on Neonatal Abstinence Syndrome have been completed by the clinicians at our NAS participating hospitals.
• Our adverse event reporting has increased significantly to 23,000 individual reports from 11 facilities. This is compared to zero reports prior to 2015.
• We are also proud to report we have 44 dues-paying members and 42 members of our federal patient safety organization—an increase in membership from 7 facilities in 2012.

Our team takes great pride in serving as a resource for healthcare providers throughout Maryland and surrounding states as well.

Take time to learn about some of our current activities in this newsletter. I encourage you to share these programs and ideas with others within your organization who may find them of interest. I would also encourage you to engage with us on social media if you haven’t already. The Center is active on both Facebook and Twitter.

As always, I welcome your input and feedback on the efforts and programming of the center. Feel free to contact me with your ideas and insights with a call or email. Wishing you a safe and healthy Summer 2018.

Sincerely,

Robert Imhoff
President & CEO