

MID-ATLANTIC
**PATIENT
SAFETY**
CONFERENCE **20
26**
APRIL 20-21 | BALTIMORE



**PATIENT SAFETY
POSTERS & AWARDS
SUBMISSIONS**

MPSC
Mid-Atlantic Patient
Safety Center





The Mid-Atlantic Patient Safety Conference 2026 shares these accepted posters.

Posters that were accepted prioritized:

- Building safety into systems, processes, technologies, environment, and culture
- Reducing reliance on memory, vigilance, or individual heroics
- Addressing root causes of harm more deeply and effectively
- Advancing equity by improving how care is designed and delivered
- Engaging a broader set of partners in safety improvement

These selections represent the thinking and action needed to shape the future of patient safety: work that not only improves outcomes but also changes the underlying systems that produce them.

Mid-Atlantic Patient Safety Conference 2026

Minogue, Circle of Honor, and Perinatal and Neonatal Fellowship Projects

Poster	Project Title	Honor	Organization	Submitter's Name	Contact Email
A	Hardwiring Medical Device Safety: A Systemwide Model for Collaboration, Recall Management, & Equity	Minogue	Johns Hopkins Health System	Stacy Shilling	sshilli3@jhmi.edu
B	Safety by Design: Embedding Team, Quality, and Access Into Everyday Practice	Distinguished Achievement	Sinai Hospital	Amanda Shrout	ashrout@lifebridgehealth.org
C	PACS Home Health HIM Reduce Lab Results Received for Non-AHCS Patients	Circle of Honor	Adventist Home Care Services	Heather Mathews	hmathews@adventisthealthcare.com
D	Huddles, Habits, and Hygiene: A Workflow-Driven Model for Sustainable and Significant Catheter-Associated Urinary Tract Infection (CAUTI) Reduction in Inpatient Rehabilitation	Circle of Honor	Adventist HealthCare Rehabilitation	Airiss Milan Finley	amfinley@adventisthealthcare.com
E	The Pressure's Off! Reducing Hospital-Acquired Pressure Injuries	Circle of Honor	Carroll Hospital	Christine Bish	cbish@lifebridgehealth.org
F	Leveraging the IHI Model for Improvement to Positively Disrupt the Status Quo of Skin to Skin in the NICU	Circle of Honor	Greater Baltimore Medical Center	Alexis Schultz	aschultz@gbmc.org
G	Hardwiring Smoke-Free Surgical Practice to Protect the Perioperative Team and Patients	Circle of Honor	Sinai Hospital	Annet Adegboyega	aadegboyega@lifebridgehealth.org

Mid-Atlantic Patient Safety Conference 2026

Minogue, Circle of Honor, and Perinatal and Neonatal Fellowship Projects

H	IMPACT - Interventions to Minimize Preventable Admissions through Care Transitions	Circle of Honor	UM Baltimore Washington Medical Center	Alisa LARBalestrier	alisa.larbalestrier@umm.edu
I	Diabetes Health Equity Transformation	Circle of Honor	UM Charles Regional Medical Center	Mary Hannah	mhannah@umm.edu
J	We All Have Skin in the Game: Preventing Pressure Injuries Together	Circle of Honor	UPMC Western Maryland	Jill LeMay	lemayjm@upmc.edu
K	Electronic Fetal Monitoring Certification: A Nurse and Provider Practice Initiative	Perinatal and Neonatal Fellow	Carroll Hospital	Brandy Fischer	bfischer2@lifebridgehealth.org
L	Bridging Gaps in Maternity Care: A Quality Improvement Approach to Doula Integration at the University of Maryland Medical Center	Perinatal and Neonatal Fellow	Maryland Moms in Training Program	Tina Larson	tlarson@umm.edu

Hardwiring Medical Device Safety: A Systemwide Model for Collaboration, Recall Management, & Equity

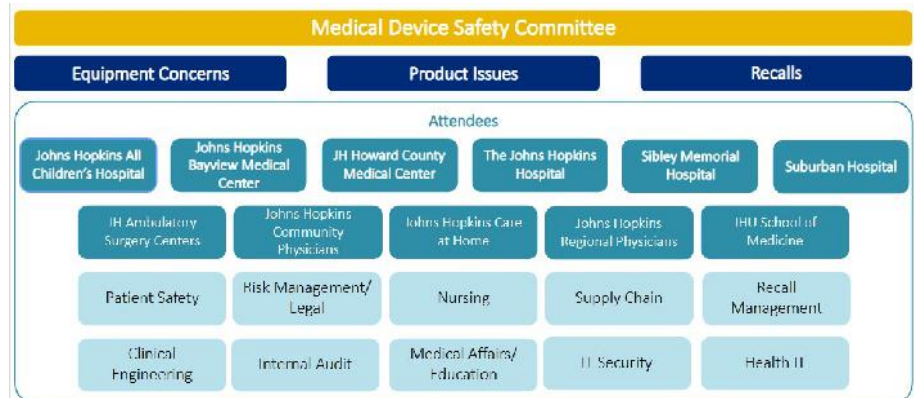
Stacy Shilling MS, RN; Nicole Fitzpatrick MPH, RN; Ashley Grooms MHIT; Jeff Natterman Esq.; Michelle Azotea, MHA; Peter Hill, MD, MS FACEP

Background

The JHHS Medical Device Safety Committee (MDSC) was established to **strengthen enterprise oversight of medical device & equipment safety** across a multistate system.

- Device, products and recall concerns were historically managed at the local level, resulting in **variation in how risks were identified, escalated, communicated, and resolved across entities.**
- Safety concerns identified at one entity were not consistently shared, resulting in **uplicated effort, inconsistent mitigation strategies, and delays in recognizing emerging device related safety trends.**

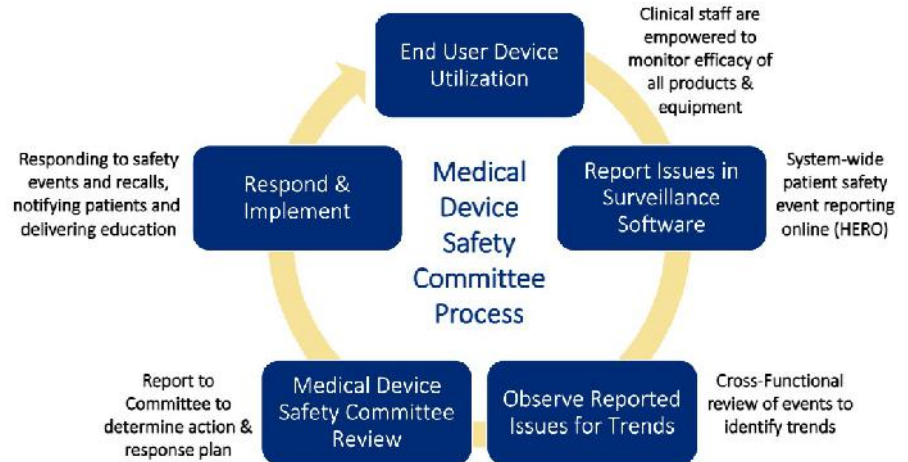
Stakeholder Engagement



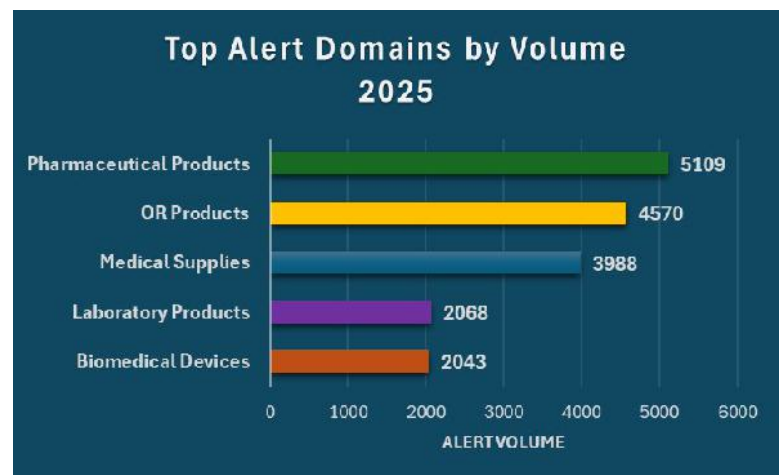
Barriers to Building Infrastructure



Workflow Process



Recalls



Annual Health System Data

Medical Devices in use	~150,000+
Products Managed	111,898
Device Recalls Managed	18,440
Patient Safety Event Reports Reviewed	1,260

Communication Tools



Conclusion

- Executive Sponsorship & stakeholder engagement are critical to assure rapid escalation, intervention & follow through.
- Subject matter experts from multiple service lines are essential to support evaluation & mitigation of device related safety concerns.
- Multiple communication pathways support timely coordination & information sharing.
- Recall Managers require access to centralized platforms with adequate data to support effective recall management.

Safety by Design: Embedding Team, Quality, and Access into Everyday Practice

Amanda Shrout, DNP, RN, CCNS, CEN, EBP(CH), CENP, Amy Shlossman, MHA, Ashley Yousefian, MS, RN, Allyn Keeney, MHA, Grace Hicks & Sarah Stanley MSN, RN, CNL, EBP(CH), NEA-BC

Background & Safety Challenge

- Following the COVID-19 pandemic, the hospital faced critical challenges: high staff turnover, declining quality and patient experience, and significant discharge barriers causing longer length of stay impacting the organization's ability to fulfill its mission of serving the community.



- In 2023, a new president joined the organization and initiated a cultural transformation by advancing three key pillars:
 - Team:** Great place to work and learn, focused on retention, engagement and culture
 - Quality:** Great place to receive care, focused on patient safety, quality and patient satisfaction
 - Access:** Care for our community, focused on patient flow and access across the care continuum

Innovations

- To address these system-level issues, the organization established complementary structures: recognition and engagement programs for team members to rebuild the workforce:
 - Recognition and engagement programs for team members to rebuild the workforce
 - Quarterly service line meetings with physician leaders to drive quality and patient experience
 - A multidisciplinary patient flow steering committee
 - Daily safety huddles

Implementation Approach

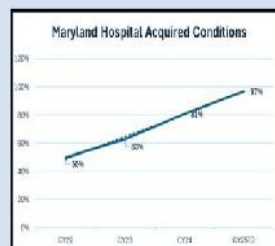
- The organization adopted a strategic understanding that a strong and engaged healthcare team is the foundation of a high-quality care delivery system.
- Safety is embedded into organizational structures, systems, and daily workflows, integrated with operational and clinical priorities.
- Selected initiatives implemented under the three key pillars include the following

TEAM Great Place to Work and Learn

- Feedback:
 - Bi-Monthly Town Halls
 - "Ask Amy" Monthly Listening Sessions
- Recognition programs:
 - "Caught in the Act of Caring" Award
 - Expansion of clinical career ladders to PT, OT and SLP as well as technicians
 - "Good Catch" awards to celebrate those who report potential safety risks
 - Sam Penn Service Excellence Awards for non-clinical team members who have impacted the patient experience

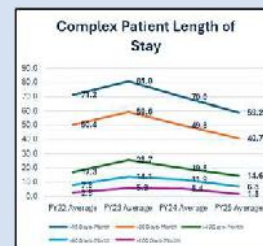
QUALITY Great Place to Receive Care

- Quarterly service line meetings with physician leadership from 12 departments focus on:
 - Mortality
 - Complications
 - Clinical documentation
 - Length of stay
 - Patient experience
- Daily safety huddles to drive accountability for safety event follow-up

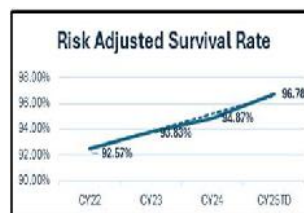


ACCESS Care for the Community

- Established Patient Flow Steering Committee
- Twice daily, interdisciplinary patient flow calls to address barriers to discharge and coordinate timely discharges
- Complex case team meets daily to manage challenging discharges and ensure safe transitions of care



Outcomes



Sustainment

Over the last two years, the central pillars have been embedded within the standard operating procedures of the organization. Key outcomes achieved:

Team

- Reduced total employee turnover to the lowest in four years, a 16% improvement from FY24
- Reduced nurse turnover to 17%, a 55% improvement from FY23
- Improved overall employee engagement by 7% from FY24 to FY25, with the organization's engagement scores rated 9 points above the US healthcare norm

Quality

- Reducing Hospital Acquired Infections (FY24 vs. FY25)
 - 67% reduction in central line-associated blood stream infections (CLABSI)
 - 73% reduction in MRSA bacteremia
 - 45% reduction in C. difficile infections
 - 63% reduction in surgical site infection hysterectomies
- Improvement in MHAC score in CY22 from 50% (penalty zone) to CY25 97% (reward zone)
- Improvement in risk adjusted mortality rate from CY22 92% to CY25 96%

Access

- Reduced case mix adjusted length of stay by 5% from FY23 to FY25
- Reduced patients with a length of stay of >20-days by 50% and >40-days by 68%
- Reduced emergency department boarding hours by 22% and overall boarders by 24%

Acknowledgements

We would like to thank and recognize all of the operational leaders and frontline clinicians who have committed to the key priorities of Team, Quality and Access day in and day out.

Adventist Healthcare's Post Acute Care HIM Dept. Reducing Lab Results Received for Non-AHC Home Care Patients

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Abstract

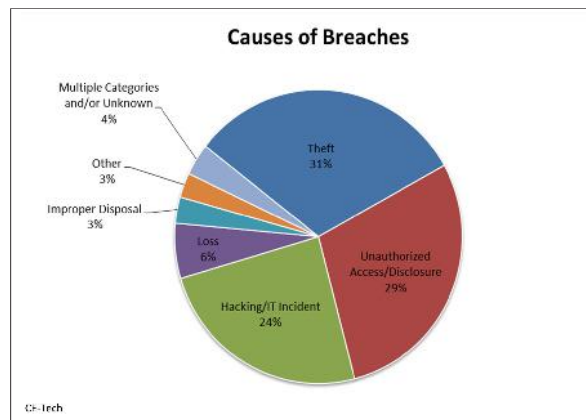
Adventist Home Care's Health Information Management (HIM) department identified a growing and serious issue: the receipt of misdirected lab results for patients who were not associated with the home care agency. The HIM team initiated a structured data-collection process to quantify the problem and bring evidence to the Quality & Safety department. After gaining the attention of Quality & Safety, the organization established direct collaboration with the external lab vendor. Together, root causes were investigated and plans were developed to correct the problem. After the project was fully implemented, the organization saw a rapid and dramatic decline of misdirected lab results, resulting in a 95% reduction.

Introduction/Background

Consider what can happen if a patient's lab results are sent to the wrong location, never reaching the intended provider overseeing their care? As a professional health organization, we have a responsibility to safeguard patient health information and protect patient privacy.

Along with the data security risk of misdirected patient information, there are significant clinical concerns when patient information ends up in the hands of those not associated with their care. "Health data is a valuable source of reliable and permanent personal information making it an attractive target" (Clarke & Martin, 2024, p. 17). According to current cybersecurity sources and HIPAA related research, "Unauthorized Access/Disclosure" is the second leading cause of healthcare data security breaches (Alder, 2026), (Figure 1).

Figure 1



When our HIM department began receiving misdirected lab results, it created dual risks – a breach of patient privacy and the possibility that the intended healthcare providers were not receiving critical lab information, posing potential threats to patient safety. The awareness of these risks spurred our efforts to resolve the situation.

Methods

The data-collection process began with our team tracking the amounts of misdirected lab results received monthly in an Excel spreadsheet. After gathering a significant amount of data and bringing it to the attention of the Quality & Safety department, we received assistance with establishing direct collaboration with our external lab vendor.

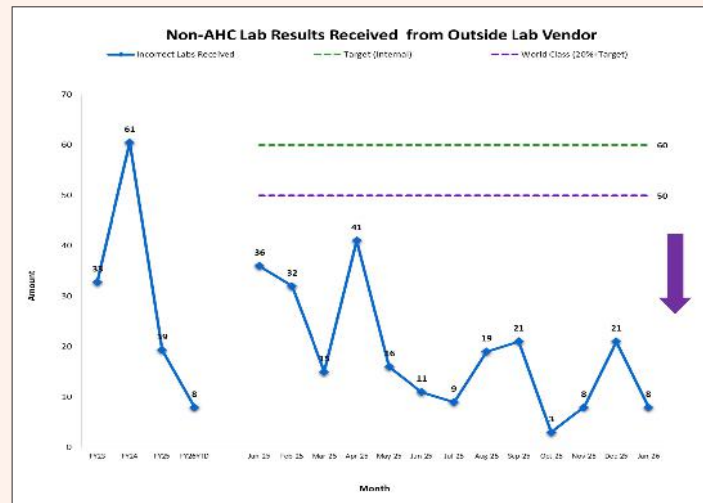
In the process of meeting with the lab vendor, root causes were investigated, and incorrect provider associations with our agency were identified within the vendor's system, as well as a need for improvements in how clinicians' lab requisition forms were being processed.

A plan was developed to alert the vendor to all incoming lab results so assignments could be corrected promptly and the list of physicians linked to the organization could be revised on an ongoing basis. Alongside this, the clinical department began participating with a new and improved service provided through the vendor for submitting lab samples and forms.

Results

Prior to the intervention, misdirected lab results rose from only occasional occurrences to receiving 60–70 per month. After the project was fully implemented, the organization saw a rapid and dramatic decline. By early 2025, monthly errors dropped to about 35, and by the summer of 2025, to around 13. In October 2025, only 3 misdirected lab results were received, reflecting a 95% reduction (Figure 2).

Figure 2



Discussion

Singh et al. (2007) have found that even with advanced EMR systems in healthcare organizations, many test results fail to reach the appropriate provider, leading to significant treatment delays. This also exposes sensitive patient information to those who should not have access to it. We are proud to have been able to combat this through the efforts of our HIM team and all those in support of our project.

Our team's achievement in the successful reduction of misdirected lab results reflects the impact of keen attention to patient data security and safety issues as well as combined and dedicated efforts to resolve patient health and privacy concerns, safeguarding medical information and promoting equitable care for every patient—within and beyond our organization.

Conclusion

Sustained monitoring continues through regular meetings between our HIM department and the lab vendor to ensure lasting accuracy and ongoing progress. This project demonstrates how accurate data, strong collaboration, and persistent follow through can resolve complex patient safety issues. It also serves as a model for other organizations facing similar data privacy challenges, emphasizing the value of teamwork, root cause analysis, and ongoing accountability.

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Huddles, Habits and, Hygiene: A Workflow-Driven Model for Catheter-Associated Urinary Tract Infection (CAUTI) Reduction in Inpatient Rehabilitation

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Abstract

Catheter-associated urinary tract infections (CAUTIs) represent a persistent source of preventable harm in inpatient rehabilitation, where patients frequently transition from acute care with indwelling urinary catheters that may no longer be clinically indicated. Enhanced surveillance at an inpatient rehabilitation facility identified nine CAUTIs between January 2024 and February 2025, with a baseline average of 9.86 infections per 1,000 catheter-days, indicating the need for system-level prevention strategies.

A multidisciplinary quality improvement initiative, *Huddles, Habits, and Hygiene*, was implemented to integrate evidence-based CAUTI prevention practices into routine care workflows. Interventions included embedding catheter necessity review into interdisciplinary daily huddles, implementing targeted chlorhexidine gluconate (CHG) bathing from “navel to knees” during routine peri-care, expanding competency-based team member education, and engaging therapy and ancillary team members in catheter safety practices.

Following implementation, the initiative achieved an 88.7% reduction in average monthly CAUTI rates, decreasing from 9.86 to 1.11 infections per 1,000 catheter-days, along with an 11.5% reduction in device utilization. The unit sustained six consecutive months without a CAUTI event, demonstrating improved reliability of catheter management practices and interdisciplinary accountability.

Embedding CAUTI prevention into existing clinical workflows improved adherence to evidence-based practices and strengthened a culture of shared accountability for device safety. This workflow-driven model offers a scalable approach for reducing healthcare-associated infections and advancing patient safety in post-acute care settings.

Introduction/Background

CAUTIs are a common healthcare-associated infection and a preventable source of patient harm. In inpatient rehabilitation, patients frequently arrive from acute care with indwelling urinary catheters that may no longer be clinically indicated, increasing the risk of prolonged device use and infection (Centers for Disease Control and Prevention [CDC], 2019). Evidence suggests targeted chlorhexidine gluconate (CHG) bathing, such as the “navel-to-knees” approach, may reduce microbial burden surrounding urinary catheters and decrease infection risk (Klein, 2023; Schmudde et al., 2019).

This project examined whether embedding catheter necessity review and CHG bathing into daily interdisciplinary workflows could reduce CAUTI rates and device utilization in an inpatient rehabilitation setting.

Methods

Design:

Quality improvement initiative using workflow redesign to reduce CAUTIs in an inpatient rehabilitation facility.

Setting and Population:

Adult patients admitted to an inpatient rehabilitation hospital with indwelling urinary catheters during their rehabilitation stay

Data Collection:

CAUTI events and catheter-days were identified through infection prevention surveillance. Rates were calculated as CAUTIs per 1,000 catheter-days. Device utilization and adherence to prevention practices were monitored monthly.

Interventions:

An interdisciplinary workgroup implemented the Huddles, Habits, and Hygiene model, which included:

- Catheter necessity review incorporated into daily interdisciplinary huddles
- Chlorhexidine gluconate (CHG) “navel-to-knees” bathing integrated into routine peri-care
- Team member education on catheter insertion, maintenance, and positioning
- Engagement of therapy team members to support safe catheter and tubing management during mobility

A standardized visual education tool (Figure 1) was used during initial nursing education and subsequent skills validation training to reinforce the CHG “navel-to-knees” bathing protocol.

Figure 1. CHG “Navel-to-Knees” bathing education tool used during initial nursing training and annual skills validation to reinforce standardized catheter hygiene practices.



Results

Implementation of the Huddles, Habits, and Hygiene model resulted in a significant reduction in CAUTIs. Average monthly CAUTI rates decreased 88.7%, from 9.86 to 1.11 infections per 1,000 catheter-days following implementation.

Device utilization also declined 11.5%, from 26.21% to 23.20%, reflecting improved reassessment and timely catheter removal.

As shown in Figure 2, monthly CAUTI events declined following implementation of the intervention, with a sustained period of six consecutive months without a CAUTI event, representing the longest zero-event period since enhanced surveillance was introduced.

Compliance with chlorhexidine gluconate (CHG) “navel-to-knees” bathing reached 87% during early implementation, demonstrating strong team member adoption of the intervention.

A single subsequent event prompted refinement of catheter management practices, including incorporation of coude catheter use for male patients into policy and compliance review of prevention practices during daily interdisciplinary huddles.

Figure 2. Monthly CAUTI events before and after implementation of the Huddles, Habits, and Hygiene intervention (March 2025), including six consecutive months without a CAUTI event following implementation.

Discussion

Embedding CAUTI prevention practices into existing interdisciplinary workflows was associated with substantial reductions in infection rates and device utilization in the inpatient rehabilitation setting. These findings support the concept that system-level workflow redesign can improve the reliability of infection prevention practices and reduce preventable harm. Integration of catheter necessity review into daily interdisciplinary huddles and targeted CHG “navel-to-knees” bathing aligns with prior evidence demonstrating the effectiveness of device reassessment and CHG bathing in reducing catheter-associated infections (CDC, 2019; Klein, 2023; Schmudde et al., 2019).

This initiative demonstrates that evidence-based prevention strategies commonly used in acute care can be successfully adapted to inpatient rehabilitation workflows across multiple campuses. While the intervention focused on targeted hygiene practices associated with catheter care, broader patient bathing routines were not addressed and represent an important opportunity for further system improvement. Future phases of this work will explore the development of standardized bathing schedules to further strengthen hygiene practices and support sustained CAUTI prevention in the inpatient rehabilitation setting.

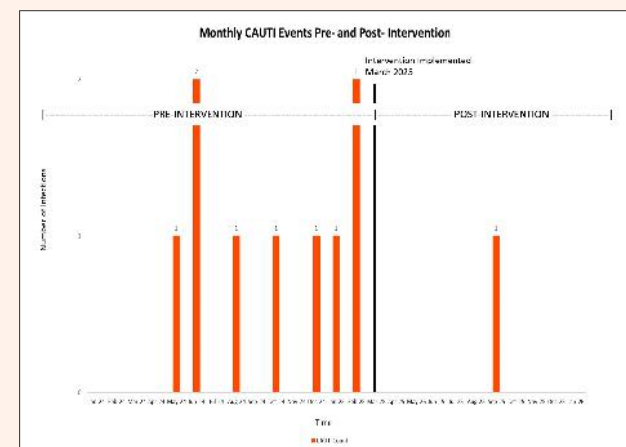
Conclusion

The Huddles, Habits, and Hygiene initiative demonstrates that embedding CAUTI prevention practices into routine interdisciplinary workflows can significantly reduce preventable harm in the inpatient rehabilitation setting. By integrating catheter necessity review into daily huddles and incorporating targeted CHG “navel-to-knees” bathing into existing peri-care routines, the initiative improved reliability of evidence-based prevention practices while minimizing additional workload for clinical teams.

These findings demonstrate that acute-care infection prevention strategies can be successfully adapted to post-acute care environments. The simplicity and workflow integration of this model support sustainability and scalability, providing a practical framework for other rehabilitation and post-acute care facilities seeking to reduce catheter-associated infections and strengthen patient safety systems.

References

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THE PRESSURE'S OFF!

REDUCING HOSPITAL-ACQUIRED PRESSURE INJURIES

ABSTRACT

During fiscal year (FY) 2023, Carroll Hospital experienced a high incidence of reportable hospital-associated pressure injuries (HAPIs) across multiple inpatient units, resulting in preventable patient harm and associated financial costs. A multidisciplinary team including nursing leadership, wound care specialists, and quality improvement professional used the **DMAIC (Define, Measure, Analyze, Improve, Control)** framework to identify root causes, set project goals, analyze trends, and implement evidence-based preventive strategies supported by workflow redesign and technology integration. As a result, the organization achieved a 64% reduction in reportable HAPIs, decreasing from 31 in FY2023 to 10 in FY2025. This improvement led to better patient outcomes, reduced risk of infection and shorter lengths of stay.

BACKGROUND

Hospital-acquired pressure injuries, which primarily affect patients who are at elevated risk, including older adults, individuals with prolonged emergency department stays, patients with immobility or impaired sensation, critically ill or medically complex patients, incontinence patients, malnutrition, moisture-associated skin damage, or extended surgical procedure times. This project focused on embedding consistent risk assessments, effective turning and repositioning schedules, appropriate offloading techniques, device-related skin protection, and improved moisture management into routine practice.

METHODS

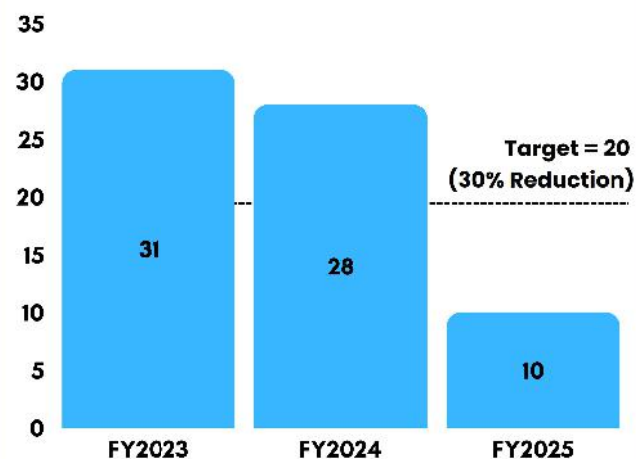
The Pressure's Off project team applied the DMAIC framework to conduct a comprehensive review integrating data analysis, direct observation, and structured root-cause analysis. Key issues identified included inconsistent risk assessments, workflow barriers affecting compliance with repositioning standards and variation in preventive measures application.

Key interventions included:

- Real-time electronic turning prompts
- 4 Eyes in 4 Hours skin assessment on all admissions and inter-unit transfers
- Automated Cerner alerts for patients with a Braden Score of 18 or less to trigger preventive orders
- Routine use of sacral Mepilex for high-risk patients and surgeries lasting more than three hours
- Standardized 30-degree repositioning using turn wedges
- Facility-wide replacement of pressure-reducing mattresses
- Leaf monitoring pilot on two hospital inpatient units
- Updates to wound care documentation standards
- Hands-on simulation-based training and intentional engagement of key stakeholders across nursing, wound care, perioperative service, emergency department and informatics.

RESULTS

The organization reported 31 hospital-acquired pressure injuries in FY2023 and 28 in FY2024. Following implementation of standardized workflows and technological enhancements, **reportable HAPIs decreased to 10 in FY2025, representing a 64% reduction.**



DISCUSSION

This project demonstrates how multidisciplinary collaboration, standardized prevention strategies, and technology-enabled monitoring contribute to meaningful reductions in preventable harm. The project is replicable and adaptable to other organizations and supports improved patient outcomes, reduced healthcare costs, and reliable care delivery.

CONCLUSION

The project remains in the Control phase of the DMAIC process, with ongoing monitoring, data review, and evaluation of new prevention technologies. Continuous interdisciplinary engagement supports sustainability and advances the goal of zero patient harm.

KUDOS

Our sincere appreciation goes to the HAPI DMAIC Committee Members and frontline nursing staff at Carroll Hospital and Executive Champion VP and CNO Leigh Chapman MS, RN, CIC, for their efforts to promote awareness, remove barriers and support our pursuit of innovative solutions.

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Method



A circular diagram representing the PDCA (Plan-Do-Check-Act) cycle. It is divided into four quadrants: 'Plan' (top right, purple), 'Do' (bottom right, green), 'Study' (bottom left, blue), and 'Act' (top left, pink). Arrows indicate a clockwise flow from Plan to Do, Do to Study, Study to Act, and Act back to Plan.

What changes can we make that will result in improvement?

Through iterative PDSA cycles, this model created a standard process for STS care for all NICU infants. Cycles of PDSA led to the creation of inclusion parameters, a standardized simulation specifically developed to address the safety barriers identified by staff and families, and visual aids to address anticipatory environmental readiness. Sustainability for this effort is monitored monthly through EPIC reports, divisional dashboards and room readiness audits.

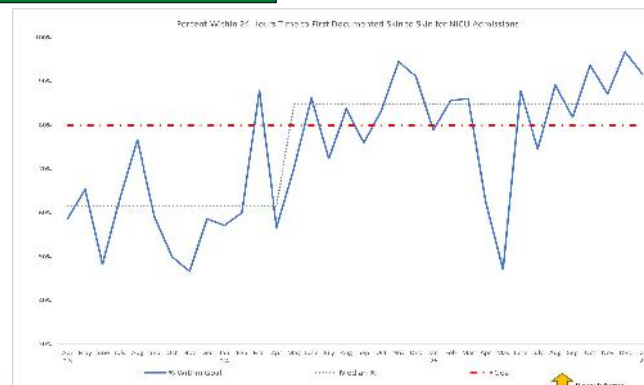
The goal of this project was for the NICU to improve the initiation time for STS holding from the baseline of 43 hours (June of 2023) to the goal of less than 24 hours by August 30, 2024.

Fig 4

- Created inclusion and exclusion criteria (Fig 1)
- Re-aligned practice and policy to remove discrepancies guiding care
- Designed a mandatory simulation in collaboration with NICU leaders, education specialist, respiratory therapists, and simulation experts (Fig 2)
- Analyzed and discussed barriers in real time during simulation activities
- Designed a room visual with families to reflect a state of anticipatory readiness for STS (Fig 3)
- Implemented a pre-planning meeting with parents and families to discuss a plan for early STS
- Created a visual on the electronic unit manager to indicate STS was completed within 24 hours since birth (Fig 4)
- Initiated a best practice advisory in Epic to visually alert the nurse that STS was due if STS had not already been documented by 12 hours of age (Fig 5)



Results



The average time to first STS for all infants was 43 hours prior to project initiation, with only 48% of all NICU infants held within 24 hours. The time to first STS improved to 13.9 hours through this initiative, with 83% of NICU infants now held within 24 hours. Results have been sustained for over one year. As a balancing measure, midline positioning was consistently maintained when clinically indicated, and there was no increase in incidence of Intraventricular Hemorrhage.

Reference

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Surgical Smoke-Free Operating Rooms: Hardwiring Safety into Perioperative Practice

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Renilda Tijones, MSN, BSN, RN, CNOR, NPD-BC
Mihyun "Rose" Jang, MSN, MPH, BSN, RN, CNOR

INTRODUCTION

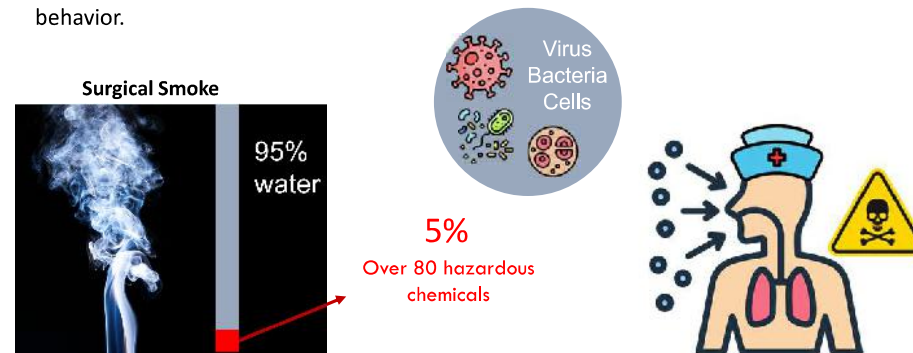
- Surgical smoke is generated in approximately 90% of operative procedures and contains carcinogens, ultrafine particles, and aerosolized biological material.
- Chronic exposure has been associated with respiratory symptoms and long-term health risks, with one day of exposure comparable to inhaling dozens of unfiltered cigarettes (Heroor et al., 2022; Merajikhah et al., 2022; Zhou et al., 2023).
- Despite known risks, smoke evacuation has historically been inconsistent (25–50% of cases), often dependent on surgeon preference rather than standardized practice.
- This variability places perioperative staff at preventable occupational risk.
- More than 20 U.S. states have enacted legislation requiring smoke evacuation (AORN, 2024; Paone, 2025).

PURPOSE

- The purpose of this quality improvement initiative was to eliminate variability in surgical smoke exposure by standardizing smoke evacuation practices in the operating room.
- The key aims for this project includes:
 - Embed smoke evacuation into routine surgical workflow as the default standard of care.
 - Increase compliance with smoke evacuation use across all procedures.
 - Reduce perioperative staff exposure to hazardous surgical smoke.
 - Establish sustainable smoke-free workflows.

METHODS & IMPLEMENTATIONS

- The intervention of standardizing smoke evacuation across all procedures in the operating room was implemented. Key components included:
- **Supply Chain Redesign:** Removal of all non-evacuation electrocautery pencils, making smoke evacuation the default.
- **Standardization of Workflow:** Universal setup of smoke evacuation in all operating rooms.
- **Education & Training:** Six-month competency-based education, nurse-led coaching, and case support.
- **Multidisciplinary Leadership:** Endorsement from Chief of Surgery and Chief of Anesthesia to reinforce shared accountability.
- **Real-Time Reinforcement:** Daily safety huddles and champion-supported implementation.
- This approach embedded safety into the environment rather than relying on individual behavior.



RESULTS

- Implementation resulted in significant improvements in compliance, standardization, and staff experience:

Metric	Baseline	Post Implementation
Smoke Evacuation Use	25-50% of cases	>95% audited compliance
Nursing Education Completion	Not standardized	100% Completed
Device Availability	Optional/Variable	Standardized and Universal
Staff Reports of Odor/Irritation	Frequently reported	Marked reduction

DISCUSSION

- Variability in smoke evacuation was driven by system and workflow design rather than lack of awareness.
- Embedding safety into the supply chain and workflow eliminated reliance on individual preference and behavior.
- Visible multidisciplinary leadership support further reinforced accountability and normalized adoption across teams.
- Sustainable practice change in perioperative settings requires alignment of workflow, equipment, and culture.

CONCLUSIONS

- Redesigning system and workflow approach effectively standardized smoke evacuation and reduced occupational exposure to surgical smoke.
- This model is sustainable, scalable, and transferable to other perioperative settings with centralized supply and education structures.
- It aligns with the growing national movement toward statewide smoke evacuation legislation and demonstrates how policy achieves impact when translated into system design and workflow standards.

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IMPACT: Interventions to Minimize Preventable Admissions through Care Transitions

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ABSTRACT

Hospital readmissions remain a persistent source of preventable patient harm and health system inefficiency, particularly for medically fragile and socially vulnerable populations. The IMPACT initiative (Interventions to Minimize Preventable Admissions through Care Transitions) was designed to reduce avoidable admissions and readmissions by intervening earlier in the care continuum—during emergency department (ED) encounters. The program redefined the role of the ED Transitional Nurse Navigator (TNN) to proactively identify and support high-risk patients through care coordination, rapid outpatient follow-up, medication access, home health referrals, and early palliative care engagement. This model is reinforced by an Epic-based, automated alert system that notifies the ED TNN and providers in real time when high-risk patients register in the ED.

Between FY24 and FY25, inpatient admission rates among high-risk patients declined from 51% to 46%, while ED discharge rates increased from 37% to 40%. By April 2025, 110 readmissions were prevented and 68 additional patients were safely discharged home. Pre/post analysis demonstrated a \$1.0 million reduction in charges across 141 patients at three months. Beyond quantitative outcomes, patients experienced improved access to medications, enhanced self-management, and reduced disparities related to insurance and social barriers. IMPACT demonstrates that embedding automated identification with nurse-led transitional care into ED workflows can sustainably improve safety, equity, and system performance.

INTRODUCTION & BACKGROUND

For patients, readmissions contribute to progressive deconditioning, especially among those medically fragile or living with advanced disease.¹ For hospitals, they increase bed occupancy, worsen ED boarding, strain resources, and lead to financial penalties.²

At UM BWMC, most admissions and readmissions come through the ED. Analysis suggested that a portion of these could be prevented through better care coordination, timely discharge follow-up, and addressing social drivers of health.³

Traditional transitional care models focus on post-discharge interventions, often missing critical opportunities during ED encounters. The IMPACT initiative sought to answer the question: Can earlier, ED-based identification and coordinated transitional care reduce preventable admissions and improve equitable outcomes for high-risk patients?

METHODS

- Design:** Quality improvement initiative focused on transitional care redesign using a pre/post evaluation framework.
- Population:** ED patients identified as high risk for hospital readmission, including those with advanced chronic disease (e.g., CHF, COPD), frequent utilization, or significant social barriers.
- Interventions:** Redesigned ED TNN role focused on high-risk or first-time admissions; IT-enabled Epic filter with TigerConnect alerts to notify ED TNN when high-risk patients register; TNN interventions including referrals to specialty clinics, arranging community/home health, addressing medication affordability, and initiating palliative care when appropriate.
- Data:** EMR-based tracking of admission/discharge rates, readmissions, and follow-up referrals; CRISP utilization and cost data, and program tracking dashboards.
- Analytic Approach:** Pre/post comparison of admission rates, ED discharge rates, readmission counts, and charges.

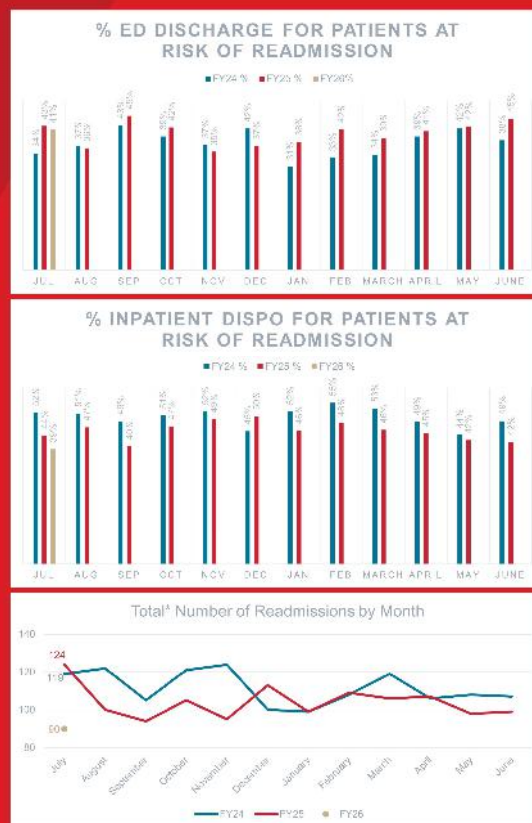
RESULTS

Quantitative Outcomes:

- 110 fewer readmissions in FY25 compared with FY24
- 68 additional safe ED discharges in FY25
- Inpatient admission rate for high-risk patients reduced from 51% (FY24) to 46% (FY25); lowest monthly rate 39% (July 2025)
- ED discharge rate increased from 37% (FY24) to 40% (FY25)
- Lowest monthly readmissions recorded in July 2025 (90 patients) since July 2023, despite higher average monthly high-risk volume
- \$1,006,487 reduction in charges across 141 patients at 3 months (CRISP pre/post analysis)

Qualitative Outcomes:

- Improved medication access and financial support
- Enhanced patient understanding and self-management
- Timely specialty and palliative care connections
- Reduced disparities for uninsured and socially vulnerable patients



Patients with system inpatient stay within 30 days, readmitted through ED at BWMC

DISCUSSION

The IMPACT initiative demonstrates that earlier, ED-based transitional care can meaningfully reduce preventable admissions while improving patient experience and equity. Unlike models that rely on retrospective identification or post-discharge follow-up, IMPACT embeds safety directly into frontline workflows through automation and nurse-led coordination. The observed reductions occurred despite increasing high-risk patient volume, underscoring the robustness of the intervention.

- Limitations include single-center implementation and observational design. Future work will explore population-specific adaptations (e.g., sepsis) and long-term outcomes.

CONCLUSIONS

- Redesigning the ED Transitional Nurse Navigator role, combined with IT-enabled real-time alerts, significantly reduced avoidable hospital utilization.
- The project demonstrated measurable reductions in admissions and readmissions, improved safe discharges, and enhanced patient experiences.
- Financially, the program reduces penalties and system strain while improving efficiency.
- Lessons learned: embedding care coordination into ED workflows, leveraging IT for timely alerts, and addressing social drivers of health are key to success.

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ACKNOWLEDGMENTS

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ED TNN: Melanie Burton, RN

Key Stakeholders:

ED CM (Maria Joseph, Alison Harris)

ED Providers & ED Nursing

PI support: Dan Cashman, Jen Tate



Diabetes Health Equity Transformation

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ABSTRACT

The UM Charles Regional Equity in Patient Care (EPC) initiative is a system-level Health Equity Transformation effort designed to identify, measure and reduce health (care) equity gaps using the Results-Based Accountability (RBA) framework. Using Turn the Curve (TTC) thinking, member organizations developed Health Equity Action Plans focused on improving outcomes for specific indicators. To support data-driven decision making, health equity dashboards were created to visualize equity gaps—such as diabetes outcomes—by race and ethnicity. The system partnered with the R.A.C.E. for Equity group to strengthen the application of TTC methodology and deepen understanding of underlying drivers of inequities. An interdisciplinary, cross-functional EPC workgroup leads this effort. At UM Charles Regional, the team is prioritizing diabetes equity gaps, aiming to reduce the proportion of non-Hispanic African American patients with out-of-range HbA1c levels (>9%) and to decrease diabetes-related readmissions through targeted, evidence-based interventions.

INTRODUCTION/BACKGROUND

The workgroup analyzed factors contributing to diabetes equity gaps to understand the “Story Behind the Curve.” Key drivers include historical distrust in healthcare—expressed by patients who feel providers do not reflect their communities—along with 26% of patients lacking a primary care provider and higher uninsured rates (16% vs. 4.5% countywide). Limited access to healthy foods and food deserts further affect outcomes. Social Drivers of Health screening, performed by Community Health Workers since January 2024, captures 95% of patients and identifies 10% with food insecurity. Innovation centered on including patients with lived experience and applying evidence-based strategies to address these equity gaps.

PROJECT DESIGN

Our hospital used the Results-Based Accountability framework and SLVR (Specificity, Leverage, Value, Reach) criteria to select strategies aimed at reducing equity gaps in diabetes outcomes. Two Key Performance Indicators monitor progress:

- **Racial distribution of out-of-range HbA1c (>9%)**
- **Diabetes-related readmissions**

The EPC workgroup—including clinical teams, community health, data analysts, leadership, and patients—reviews progress and adapts interventions.

METHODOLOGY

1. Data-Driven Approach

Equity dashboards track HbA1c by race/ethnicity. SDOH screening (95% capture; 10% food insecurity) informs resource needs.

Patient/Family Advisory Council (PFAC) provides lived-experience input.

2. Strategy Selection (SLVR)

Each intervention was evaluated for impact, feasibility, and ability to reach disproportionately affected patients.

IMPLEMENTED STRATEGIES

- PFAC engagement for strategy refinement
- \$5,000 support fund for uninsured/self-pay diabetes supplies
- Expansion of Wheels to Wellness/Lyft transportation
- Food is Medicine partnership (Hungry Harvest)
- Consolidated 1-page education resource
- Telehealth booths with public libraries
- Strategically planned outreach to African American communities
- WebMD Ignite Diabetes Risk Assessment + marketing campaign
- CGM education and distribution via Diabetes Center & TNN team
- Mobile Integrated Health home-based diabetes support

DISCUSSION

Our effort to advance equity in diabetes management has been sustained through consistent quarterly EPC Diabetes workgroup meetings, where real-time data is reviewed to ensure continued focus and impact. Before each meeting, all diabetes cases flagged as Prevention Quality Indicators (PQIs) are analyzed, enabling the team to understand trends, reconnect with the project's purpose, and adjust strategies as needed.

To support replication at other hospitals, our team emphasizes the importance of transparently sharing our process, action-planning steps, and lessons learned. Platforms such as the Mid-Atlantic Patient Safety Center provide opportunities to disseminate best practices and promote regional improvement. This initiative aligns with Joint Commission National Patient Safety Goals (NPSGs) and CMS health equity standards. While regulatory alignment is important, the true motivation remains the lives improved—and limbs saved—through more equitable diabetes care in our community.

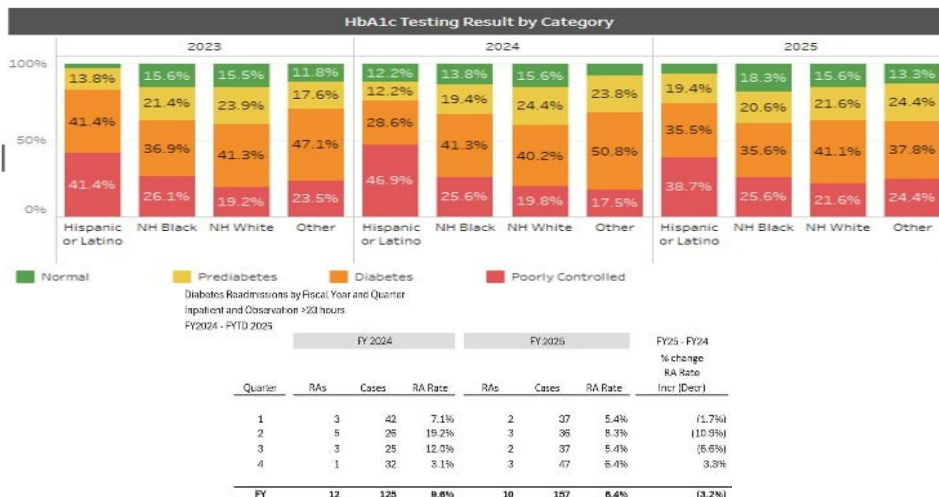
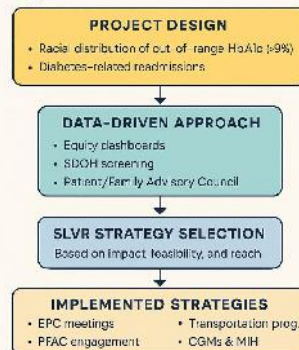
CONCLUSION

Although it is early to see the full impact of our efforts, we have preliminarily observed a narrowing of the equity gap in “out-of-range” HbA1c levels. We have also noted a 3.2% reduction in diabetes-related readmissions.

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Design & Methodology



We All Have Skin in the Game: PREVENTING PRESSURE INJURIES TOGETHER

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KEY LEARNING: By recognizing that we all have skin in the game and taking a broad, innovative approach to prevention, the prevalence of hospital acquired pressure injuries can be greatly reduced!

EXECUTIVE SUMMARY

During 2023, the facility experienced a consistent rise in hospital-acquired pressure injuries (HAPIs), with a prevalence of 0.87 per 1,000 patient days, impacting patient outcomes, financial performance, and public safety ratings. Recognizing the urgency, a comprehensive, hospital-wide initiative was launched to address root causes and implement targeted prevention strategies within the facility comprised of Emergency, Observation, Intensive care, Cardiac Stepdown, Med-Surg, Labor & Delivery, Obstetrics, Nursery, Rehabilitation, Behavioral Health, and Perioperative areas.

Root Cause Analyses revealed key contributing factors including prolonged Emergency Room and inpatient hospital stays, inconsistent use of evidence-based practices, delayed wound care consultations, and limited interdisciplinary collaboration. In response, the hospital implemented several innovative interventions including but not limited to:

- **Emergency Department (ED):** Hospital beds with improved pressure relief mattresses provided for patients boarded >1 hour
- **Perioperative Areas:** Adoption of Scott Triggers Risk Assessment with preventive equipment utilized based on scoring
- **Magnetic Resonance Imaging (MRI) Suite:** Upgraded table pads for enhanced pressure distribution and comfort
- **Wound Care (WC):** Expanded coverage to 10 hours/day, 7 days/week
- **Ambulation Assistants & Respiratory Therapy (RT):** Engaged in early skin issue detection and WC consults
- **Sacral Dressings:** Applied on day 5 of admission to prevent skin breakdown in this common pressure injury area
- **Clinical Documentation Integrity (CDI) and Hospital Medicine (HM) collaboration to ensure proper classification** of pressure injuries, preventing misattribution of present-on-admission (POA) wounds

To reinforce compliance, Patient Safety Rounds began in Q4 2024, auditing key preventive practices and providing real-time education. Documentation enhancements in the electronic health record supported accurate coding and wound tracking.

Despite earlier challenges in 2024, the initiative yielded significant improvement. By September 2025, the HAPI rate dropped to 0.32 per 1,000 patient days, outperforming the Agency for Healthcare Research and Quality (AHRQ) benchmark of 0.70 and demonstrating the effectiveness of a multidisciplinary, data-driven approach to patient safety.

Replication and sustainability of this robust plan can be accomplished through an organizational commitment to HAPI prevention in all direct patient care areas; careful identification of root causes; development of impactful action plans which focus on processes and utilization of evidence-based tools; investment in high-quality HAPI prevention equipment; automated electronic health record alerts; consistent standard prevention practices; frequent reinforcement of expectations and ongoing support to clinical staff; CDI involvement; and continuous monitoring and adaptation of the plan until goals are met and sustained.

PROJECT OVERVIEW AND SAFETY CHALLENGE

During baseline year 2023, there was a high prevalence of HAPIs in the facility, reflecting a rate of 0.87 per 1,000 patient days during the calendar year. Six of the HAPIs were Patient Safety Indicator 3s (PSI 3s) (stage 3, 4 and unstageable). These injuries were occurring in a widespread fashion across units and patient populations, negatively impacting patient outcomes and hospital reputation.

Medicare estimates that each HAPI adds an average of \$43,180 to a hospital visit bill. Costs related to hospital acquired conditions cannot be charged to the patient, resulting in a financial strain on the facility. The Leapfrog Patient Safety Grade and Centers for Medicare & Medicaid Services (CMS) Star Rating were also negatively impacted by these results. In response, the hospital launched a system-wide initiative to enhance HAPI prevention practices and reduce occurrences within its walls.

ROOT CAUSE UNDERSTANDING AND INNOVATION

In 2024, the Patient Safety team facilitated Root Cause Analysis & Action (RCA2) for each PSI 3. A thorough multidisciplinary review of each case was conducted, the Just Culture algorithm was followed, and action plans were initiated. Commonly identified causative factors included extended length of hospital stays with HAPIs occurring later in the visit (past day 5), lack of consistent evidence-based prevention practices/tools, delayed WC consultations and evaluations, poor collaboration and continuity among units and disciplines, and a heavy reliance on inpatient units for pressure injury prevention.

IMPLEMENTATION APPROACH

Early in the process, it was identified that outpatient and ancillary areas could enhance processes and equipment to reduce pressure related skin breakdown. In response to these findings, several initiatives were implemented:

- For Emergency Department (ED) patients boarded upon stretchers, an Operations Center process was developed wherein a hospital bed with pressure relieving mattress was delivered to each patient who was admitted but would not receive an inpatient bed assignment within 1 hour. This practice limited the amount of time patients lay on stretcher mattresses.
- The evidence-based peri-operative specific Scott Triggers Pressure Injury Risk Assessment tool was implemented with associated prevention measures based on scoring; patients at risk/undergoing lengthy procedures were provided with equipment such as preventive dressings and table pads in the Operating Room (OR), Interventional Radiology (IR) and Interventional Cardiology (IC) settings.
- Existing MRI table pads were replaced with a high-quality alternative which further reduces pressure and improves patient comfort during imaging.
- WC coverage was extended from 8 hours five days/week to 10 hours seven days/week to ensure consistency in services and prompt evaluation of new wound findings by specially trained staff.
- Ambulation assistants were recruited to complete a body map to alert the WC team of any new skin issues detected during their sessions with patients.
- RT was given autonomy to enter a WC consultation for any nasal bridge injury detected which resulted from CPAP/BIPAP mask use. This process facilitated prompt WC assessment and treatment for the affected patient population as soon as skin breakdown was identified.
- A preventive dressing application program on day five of admission was trialed. Recognizing that some dressings were being used for treatment, each was marked accordingly with a "P" for prevention or a "T" for treatment. The inpatient unit trialing this process achieved complete elimination of new HAPIs during a 30-day trial period. As a result, the automated alert process identifying patients on admit day 5 was replicated and the preventive dressing process was implemented on all inpatient units throughout the facility by Q2 2024.

A series of six monthly "HAPI Hour" education sessions was conducted from July to December 2024 to share vital information with clinical staff and enhance HAPI prevention. Topics for these sessions included: 1) Preventive Sacral Dressings and Day Five Application Process 2) Daily Bathing and Hygiene 3) Dietary Requirements and Supplements 4) Heels up, Heel Dressings and Heel Medix Boot 5) Specialty Beds and Positioning Equipment 6) Putting It All Together. When these sessions were completed, WC began offering weekly "Wound Care Wednesday" education sessions via a mobile cart. This enabled the WC team to take information to each inpatient unit, maximizing their reach for clinical staff members throughout the hospital.

In Q3 2024, event reviews for each Stage 1, Stage 2 and Deep Tissue Injury (DTI) were conducted at the unit level using a standardized electronic form. This allowed unit leaders and frontline staff to use a consistent method in identifying causative factors for HAPI at the local level and create action plans specific to their respective areas.

Due to decreased mobility from law enforcement (LE) restraint equipment such as shackles and handcuffs, a mobility plan specific to prison inmates was developed with assistance from hospital security. Additionally, a process to apply a protective sacral dressing and dressings beneath LE restraints was implemented for all prisoners at time of admission to the hospital. These two initiatives helped to ensure equity for this subset of patients.

In Q4 2024, Patient Safety began a rounding program to promote and support adherence and monitor compliance with prevention initiatives. Patient Safety Rounds (PSRs) were conducted once monthly on each inpatient unit after an initial thirty-day trial on the critical care units. Five to ten patients were visited each week, and specific elements of preventive care were audited to include: turn and positioning every two hours, heels up, preventive sacral dressing, and daily hygiene. Education to staff was provided real-time when elements were missed and all opportunities and successes were reported to unit leadership. Electronic health record reminders were added for nursing staff to document presence of the preventive 5-day sacral dressing and photograph each new wound at the time of discovery.

During event reviews, it was identified that some pressure injuries were being coded as hospital acquired when it appeared in nursing documentation that they were not. The CDI team was tasked with detailed reviews of potential HAPIs, and a process to query providers regarding POA status was initiated to ensure accuracy in final coding. Education was offered to providers to reinforce the process for identification of HAPIs within the medical record. This initiative prevented the hospital from taking responsibility for pressure injuries that were, in fact, POA.

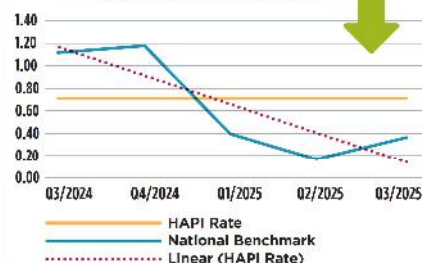
IMPACT AND OUTCOMES

As efforts continued through 2024 the rate of HAPIs began to trend downward. However, due to poor performance in Q1 and Q2, the overall rate for CY24 increased to 1.00 per 1,000 patient days. Seven of these HAPIs were reported as PSI 3s.

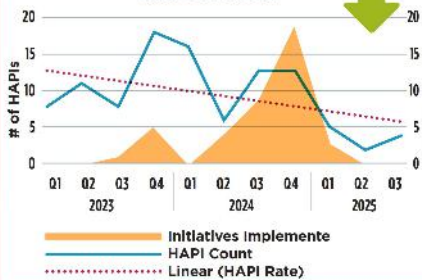


Following the full implementation of all these major initiatives along with several other prevention enhancements, the facility realized a marked reduction in HAPIs during 2025. Through September of 2025, the HAPI rate has consistently trended downward. To date, the rate per 1000 patient days is 0.32 with zero PSI 3 HAPIs. This performance exceeds the AHRQ benchmark of 0.70.

HAPI Rate by Quarter



HAPI Trend by Quarter 2023-CYTD 2025



SUSTAINABILITY, SPREAD, AND REPLICABILITY

Engagement of staff in all areas of the hospital is the cornerstone to the effectiveness of this program. Providing them with the knowledge, tools and support they require to be successful has made a remarkable impact on the HAPI prevention care that is provided to patients.

This program can be easily replicated through dedication to a system level redesign that involves HAPI prevention in all care areas. Creating automatic processes, alerts and reminders for interventions such as moving boarded ED patients into hospital beds, placing protective sacral dressings on day 5 of admission, and utilizing evidence-based tools such as Scott Triggers makes it easy for effective preventive measures to be consistently utilized. Performing RCA2 event reviews and following the Just Culture decision tree eliminates blame and promotes focus on psychological safety, process improvement, high reliability, and positive patient outcomes.

ELECTRONIC FETAL MONITORING CERTIFICATION

A Nurse and Provider Practice Initiative

Abstract:

After experiencing potentially preventable safety events, we examined root causes and found that increasing EFM certification improves nurse and physician identification and responsiveness to EFM tracings. To enhance maternal and neonatal outcomes we are recommending to mandate EFM certifications for Labor & Delivery Nurses, Midwives and OB Providers.

Introduction / Background:

- Reason for Action: Standardizing EFM certification requirements:
- Allows teams to communicate with standard terminology and intervene quickly in emergent situations
 - Decreases poor maternal and neonatal outcomes/harmful events
 - Provides ongoing education and knowledge testing
 - Supports nursing staff to practice at the top of their scope
 - Builds collaboration between providers and nurses

Methods: Root causes of nurse / physician response and interventions related to EFM changes



Education

NCC interpretation standards and terminology, knowledge of available resources, documentation accuracy

We conducted a pulse survey to identify barriers and resources to successfully increase certification



Equipment

Accessibility to view EFM tracings at all times

Tracing hardware & accuracy, connection between Fetalink and Cerner



Staffing

Patient ratios (nurses and providers)

Provider structure & standard of who is on site

Safe Cares – Safety tracking system to submit delays in care /responsiveness for review

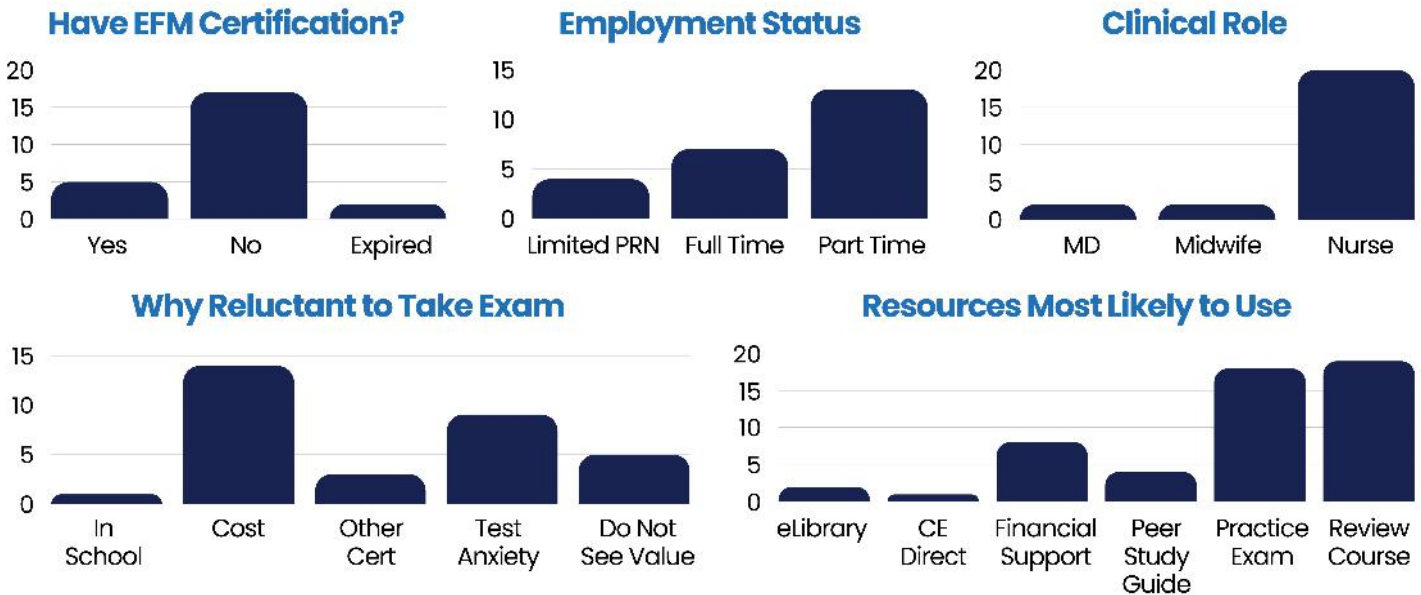


Communication

No standard way to communicate with nurses / providers (text, calls, paging)

Use of language standard CUS words (Concerned, Uncomfortable, Safety issue) to escalate concerns

Results of Electronic Fetal Monitoring Staff Survey (24 Participants):



Standardizing EFM certifications is expected to improve timely recognition and response, ultimately improving maternal & neonatal outcomes. Our next steps are:

- Safety Attitudes Questionnaire Survey: Frontline Perspectives – In Process (Nurses, Physicians, OB Techs, Leadership)
- Funding Approval, Resource Allocation, Medical Group Support, and HR Review

Bridging Gaps in Maternity Care: A Quality Improvement Approach to Doula Integration at the University of Maryland Medical Center

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Background

Research demonstrates that doulas provide emotional, informational, and advocacy support that improves maternal experiences and clinical outcomes, including reduced cesarean rates, decreased intervention use, and increased breastfeeding success. While many physicians, midwives, and nurses acknowledge these benefits, their attitudes remain mixed, often influenced by role ambiguity, concerns about scope of practice, and occasional tension within clinical teams. Policy and population-level evidence further identifies doula care as a cost-effective approach to improving birth equity and outcomes, particularly for underserved populations, though access and integration into healthcare systems remain inconsistent. Qualitative findings also suggest that doulas can enhance patient empowerment, communication, and trust, but may be perceived by some clinicians as challenging medical authority when roles are not clearly defined. Overall, the literature highlights the importance of clear role delineation and collaborative, respectful interdisciplinary models to optimize the integration and impact of doula care.

Goal

The goal is to become a **doula-friendly hospital** by integrating doulas as collaborative members of the maternity health care team to enhance patient-centered support prenatally and during labor & birth, through postpartum recovery by:

- creating education and training for hospital staff.
- providing doula-staff relationship building sessions and tours.
- improving patient satisfaction with birth experiences by fostering equitable, respectful, and holistic maternity care.
- reducing unnecessary interventions.

Problem

UMMC lacks standardized policies, workflows, and staff education to support consistent integration of doulas into maternity care. Patients with established prenatal care at the UMMC have underutilized community doula services. This results in limited and inconsistent access to doula support for eligible patients, undermining patient-centered care during labor, birth, and postpartum recovery.

SO WHAT?

Doula supported care has shown to improve birth outcomes, enhance maternal & postpartum outcomes, and improve patient experience & satisfaction.

FIRST STEP – Collect Data!

Staff Survey and Conversations:



Framework

P (Population):

Birth patients & families receiving maternity care services (prenatal, labor & birth, through postpartum recovery) at the UMMC affiliated care sites.

I (Intervention):

Integration of doulas as collaborative members of the maternity care team — including the implementation of hospital policies, workflows, staff education/training, and relationship-building initiatives that promote consistent doula involvement.

C (Comparison):

Standard maternity care without doula integration involvement via patient satisfaction surveys and staff feedback.

O (Outcomes):

- Strengthened teamwork between doulas and hospital staff.
- Improved equity, respect, and holistic care through development of training tools.
- Increased patient satisfaction with birth experiences
- Reduced unnecessary medical interventions (cesarean sections, inductions, etc.).

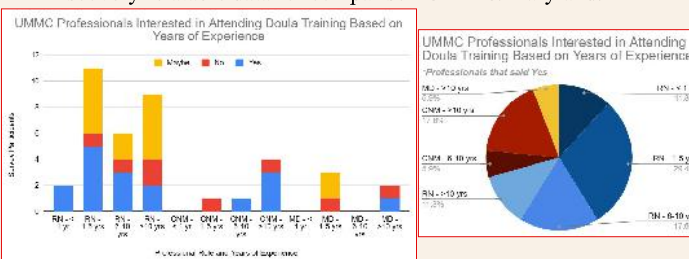
Implementation

- **By Summer 2026**, to establish a team that coordinates quarterly networking events at UMMC providing tours and team building opportunities between staff and community doulas with the goal to encourage collaboration, role descriptions and expectations, along with building a community resource list of doula contacts interested in supporting our patients.
- **By Winter 2026**, UMMC will begin to implement standardized policies, workflows, and staff education to formally integrate doulas as collaborative members of the maternity care team, resulting in increased doula involvement in hospital births, as measured by documented doula participation in the electronic health record which is currently not measured.

Results

Findings & Barriers:

- Gain support from the UMMC interdisciplinary perinatal team.
- Discovery reliable data for comparison UMMC/Maryland.

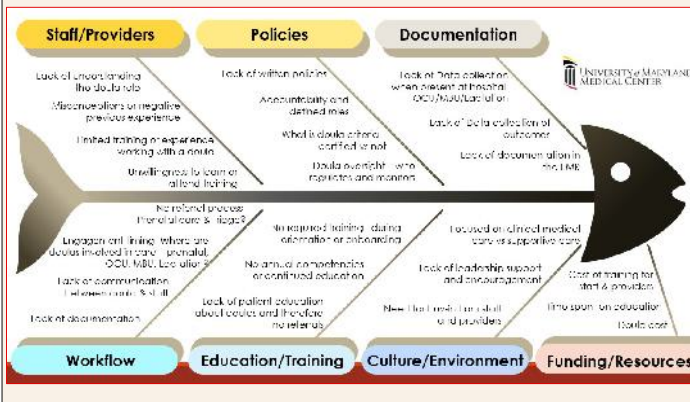


Next Steps:

- Organize an informational session for the UMMC team in collaboration with doula stakeholders to define the doula role, provide education, and present relevant research findings.
- Collaborate with staff to develop a formal policy.
- Plan an initial networking event with community doulas, including a facility tour and staff meet-and-greet.
- Create a resource list of community doulas for patient access.
- Ensure access to accurate data collection and interpretation.
- Implement a plan for data collection in the electronic medical record (EMR).

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REFERENCES:



Mid-Atlantic Patient Safety Conference 2026 Poster Submissions

Poster	Project Title	Topic	Submitter's Organization	Submitter's Name	Contact Email
1	Interdisciplinary Approach to Improve the Care Delivered to Patients Admitted with Sickle Cell Crisis	Care Transitions and Coordination	UM Baltimore Washington Medical Center	Savannah Ransom	savannah.ransom@umm.edu
2	Reduction of Hospitalizations related to CHF utilizing Wellness Calls	Care Transitions and Coordination	Adventist HealthCare Home Care Services	Susan Lightner	mlightne@adventisthealthcare.com
3	Transforming Diabetes Care: Embedding a Diabetes Nurse Practitioner in Transitional Care to Drive Proactive, Equitable Management	Care Transitions and Coordination	UM Baltimore Washington Medical Center	Caitlin Nass	Caitlin.Nass@umm.edu
4	Interagency Collaboration: ICARE Program Assists Vulnerable Populations and Reduces Healthcare Overutilization	Care Transitions and Coordination	LifeBridge Health Northwest Hospital	Danielle Geier	dgeier@lifebridgehealth.org
5	Improving Medication Access for Sexual Assault Patients to Enhance Safety and Patient Satisfaction	Emergency Department	MedStar St. Mary's Hospital	Jennifer Alvey	jennifer.m.alvey@medstar.net
6	From Chaos to Coordination: Using Continuous Improvement Best Practices and High Reliability Principles to Optimize Patient-Centered Flow in the Emergency Department	Emergency Department	LifeBridge Health Northwest Hospital	Ishmel Fulton	ifulton@lifebridgehealth.org
7	Reducing LWBS (Left Without Being Seen) in the Emergency Department	Emergency Department	Luminis Health Anne Arundel Medical Center	Brian Kelly	dkelly3@luminishealth.org

Mid-Atlantic Patient Safety Conference 2026 Poster Submissions

8	A Multidisciplinary Model for Hardwiring Language Equity for Patients with Limited English Proficiency	Health Equity, Access & Inclusive Care	LifeBridge Health Sinai Hospital	Lan Miller	llmiller@lifebridgehealth.org
9	Reducing Self-Discharge and Hardwiring Safe, Equitable Care in Outpatient Rehabilitation	Health Equity, Access & Inclusive Care	Adventist Healthcare	Sweta Diwan	sdiwan@adventisthealthcare.com
10	Implementing Best Practices for Human Trafficking Identification Across Our Healthcare System	Health Equity, Access & Inclusive Care	LifeBridge Health	Jessica Wilson	jwilson@lifebridgehealth.org
11	Collaborate to Extubate! Reduce Risks and Build Relationships	Hospital Acquired Conditions - Critical Care	Johns Hopkins Bayview Medical Center	Julianne Woodbury	jwoodbu5@jh.edu
12	Reducing mechanical ventilation using an evidence-based bundle with a focus on delirium	Hospital Acquired Conditions - Critical Care	UM, Baltimore. LifeBridge Health Sinai Hospital	Jasmyn Berkley	jberkley@umaryland.edu
13	Non-Pharmacologic Management of Orthostatic Hypotension	Hospital Acquired Conditions - Falls	LifeBridge Health Sinai Hospital Rehabilitation	Laura Steakin	laura.steakin@mcdaniel.edu
14	The Pressure Injury Elimination (P.I.E.)	Hospital Acquired Conditions - Pressure Injury	Christiana Care Union Hospital	Donna Buettner-Hartsoe	Donna.Buettner-Hartsoe@christianacare.org
15	Sub-Epidermal Moisture (SEM) Scanner for Early Detection and Prevention of Pressure Injuries	Hospital Acquired Conditions - Pressure Injury	UM Upper Chesapeake Medical Center	Martin Koehnlein	Martin.Koehnlein@umm.edu
16	Championing Evidence-Based Practice: A Collective Approach to Reduce HAPI	Hospital Acquired Conditions - Pressure Injury	MedStar Good Samaritan Hospital	Karen Droter	Karen.Droter@medstar.net
17	The Gut Guardians: Reducing C.diff	Infection Prevention - C. diff	LifeBridge Health Carroll Hospital	Colleen Hordesky	chordesky@lifebridgehealth.org
18	Executing Multidisciplinary Strategies to Lower Central Line	Infection Prevention - CLABSI	MedStar Southern Maryland Hospital Center	Jennifer Bierbaum	jennifer.bierbaum@medstar.net

Mid-Atlantic Patient Safety Conference 2026 Poster Submissions

	Blood Stream Infections (CLABSI) and Enhance Quality				
19	Using HRO Principles to Eliminate CLABSIs in Our ICU	Infection Prevention - CLABSI	Ascension St. Agnes Hospital	Wendy Lincoln	Wendy.Lincoln@Ascension.org
20	The Sustained Impact of a Purposeful Pause to Prevent CLABSI	Infection Prevention - CLABSI	LifeBridge Health Sinai Hospital	Kirk Huslage	dhuslage@lifebridgehealth.org
21	OB Navigation Program Analysis: How Reviewing a Program can Improve Quality and Safety	Maternal/Perinatal Safety	LifeBridge Health Carroll Hospital	Brittany Osburn	bosburn@lifebridgehealth.org
22	When Teamwork Makes the Dream Work: How the Creation of a Quality Management Collaborative Impacted Maternal Health and the Health of a Hospital	Maternal/Perinatal Safety	LifeBridge Health Carroll Hospital	Susan Hoffman	shoffman@lifebridgehealth.org
23	Embedding Bereavement Care into Patient Safety Systems: A Trauma-Informed and Equitable Approach to Perinatal Loss	Maternal/Perinatal Safety	Aaliyah in Action	Elizabeth O'Donnell	hello@aaliyahinaction.org
24	Right Route, Right Time: Leveraging Pyxis Alerts to Prevent Administration Errors	Medication Safety	MedStar Georgetown University Hospital	Harriet Kusi	Harriet.kusi@gunet.georgetown.edu
25	Improving Patient Experience in the Endoscopy Suite	Patient Experience	Luminis Health Anne Arundel Medical Center	Sarah Brace	sbrace@luminishealth.org
26	Interdisciplinary Nursing and Provider Joint Mock Codes: Enhancing Early Code Response and Team Performance	Simulation	The Johns Hopkins Hospital	Krupa Patel	kpatel33@jhmi.edu

Mid-Atlantic Patient Safety Conference 2026 Poster Submissions

27	Transforming Patient Safety: A Nurse-Led Rapid Response Model	Systems, Culture, and Reliability	MedStar Southern Maryland Hospital Center	Elizabeth Shannon Walters	elizabeth.s.walters@medstar.net
28	Access Redesign for Safe and Equitable Patient Experience	Systems, Culture, and Reliability	Adventist HealthCare Rehabilitation	Cindy Roa	croa@adventisthealthcare.com
29	Safety Coach Program - Improving a Culture of Safety Through Peer Coaching	Systems, Culture, and Reliability	CalvertHealth Medical Center	Brittany Lyon	brittany.lyon@calverthealthmed.org
30	Shorter Stays, Stronger Care: Reducing Pediatric Endocrine Length of Stay through QI	Systems, Culture, and Reliability	UM Medical Center	Samantha McQueen	samantha.mcqueen@umm.edu
31	TRACKing What Matters: Closing the Loop on Complex Problems	Systems, Culture, and Reliability	UM Medical Center	Meghan Schott	mschott@umm.edu
32	Transforming Quality Improvement Through AI-Driven Insights	Technology, Data & Digital Innovation	LifeBridge Health Northwest Hospital	Danielle Geier	dgeier@lifebridgehealth.org
33	Their Safety. Their Voices. Our Promise	Technology, Data & Digital Innovation	LifeBridge Health	Anson Babu	ababu@lifebridgehealth.org
34	AHC Reducing Form Fatigue Through the Power of One - A Smarter Way to Report Events	Technology, Data & Digital Innovation	Adventist HealthCare	Ara Venice Flores	aveniceflores@adventisthealthcare.com
35	Improving Staff and Patient Safety Through Redesign of Safe Patient Handling and Mobility Education	Workforce Safety	UM Charles Regional Medical Center	Melissa Zalesak	mzalesak@umm.edu
36	Sharpening our Focus on Workplace Violence Prevention and Response	Workforce Safety	Frederick Health	Kirsten Edler	kedler@frederick.health
37	CalvertHealth Cares: A Commitment to Violence-Free Workplaces	Workforce Safety	CalvertHealth	Kara Harrer	kara.harrer@calverthealthmed.org

Interdisciplinary Approach to Improve the Care Delivered to Patients Admitted with Sickel Cell Crisis

Savannah Ransom MSN RN, Dr. Jeffrey Marshall, Dr. Omoyemi Adebayo, Dr. Harvinder Singh, Monica Tong PharmD, Kyle Hunt PharmD, Stephanie Bradfield RN CCM, Melanie Burton RN, Nicole Kiehle PharmD, and Benjamin Young PA-C



BACKGROUND & SIGNIFICANCE

- 100,000 people in the US suffer from sickle cell disease, with vaso-occlusive crisis as the most common reason for admission for those affected by sickle cell disease¹.
- The readmission rate is high among those suffering from sickle cell disease due to vaso-occlusive crisis¹.
 - Facility readmission rate 1 year prior to pilot=27.1%.
- Clinical practice guidelines are commonly used to provide standardized care while reducing length of stay and readmission rates¹.
- While reviewing local cases, it was identified that there was a lack of care guidelines to support provider treatment along with concern among nursing staff caring for patients requiring such high doses of opioids.

PURPOSE

- To address these issues, an interdisciplinary group was formed.
- This group was charged with focusing on four key process changes which included:
 - Building a sickle cell treatment guideline.
 - Creating a comprehensive patient-controlled analgesia (PCA) order set.
 - Developing nursing education about sickle cell crisis.
 - Building sickle cell treatment care plans to be used across patient encounters.

METHODS

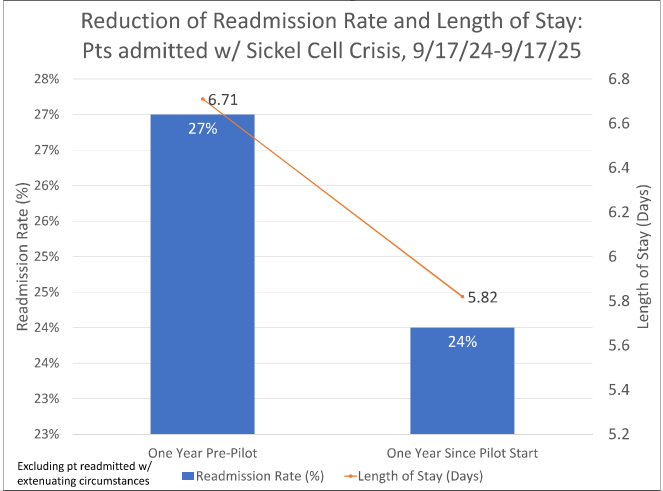
- Patients admitted with sickle cell crises were cohorted on the Intermediate Care Unit (IMC) at the start of the pilot.
- Pilot ran from September 17, 2024, through the next year.
- Specific data points both pre- and post-pilot start were tracked by nursing and pharmacy representatives.
- Sickle cell treatment guideline created, includes:
 - Monitoring requirements
 - Triage recommendations
 - Dosing recommendations for both PCA and non-PCA opioid treatment management
- PCA order set built and includes:
 - Sickle cell crisis as an indication
 - Dosing recommendations
 - Monitoring parameters
 - Other interventions necessary such as linked carrier fluids, bowel regimen, vital sign frequency, etc.

METHODS, CONT.

- Education created and provided to IMC staff by IMC Clinical Outcomes Coordinator and Unit Educators. The education included:
 - Pathophysiology and care of patients admitted with sickle cell crisis
 - Indicators for decompensation specific to sickle cell crisis
 - Administration and management of PCA infusions

RESULTS

- A total of 59 patients admitted with sickle cell crisis during pilot.
 - Average time to first dose =2 hrs, 14 mins (goal is ≤ 60 mins)
 - 41% needed PCA intervention
 - Average length of PCA use was 4.08 days
- Reduced adverse events related to underlying illness and worsening symptoms among admitted sickle cell crisis patients.
 - One year Pre-pilot: Two patients with Acute Chest Syndrome and two patients passed
 - One year Post-pilot: One patient with Acute Chest Syndrome and no patients have passed
- Improved nursing and provider understanding of disease process and treatment plan among admitted sickle cell crisis patients.
- The PCA order set is live with reported ease of use.



CONCLUSIONS AND NEXT STEPS

- Having a clinical practice guideline decreases the length of stay and readmission rate of those in vaso-occlusive crisis from sickle cell disease. Additionally, there is an added benefit of being able to treat patients locally and have their community support systems more proximal during a crisis.
- Next Steps
 - Build treatment care plans in EPIC to lead physicians in treatment across patient encounters to provide better continuity of care and reduce readmission rates².
 - Reduce opioid requirements among admitted sickle cell crisis patients.
 - The current state in EPIC does not allow tracking of total opioid requirements Working with Quality, Pharmacy, and IT to develop a process to capture this data.
 - Continue to coordinate within the workgroup to create triage guidelines for patients being admitted to Acute vs Critical Care.

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Reduction of Hospitalizations Related to Congestive Heart Failure (CHF) Utilizing Wellness Calls

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Abstract

Heart failure (HF) is a leading cause of preventable hospital readmissions, particularly among patients transitioning from hospital to home health care. In alignment with the Centers for Medicare & Medicaid Services (CMS) priority to reduce avoidable harm and readmissions, the Heart Failure Wellness Call Initiative was developed to improve post-discharge outcomes for patients with congestive heart failure (CHF). The program implemented a structured, four-week intervention consisting of weekly proactive telephone calls focused on early identification of symptom exacerbation, medication nonadherence, and barriers to care.

A pre-post analysis of organizational readmission data from 2025 was conducted to evaluate program effectiveness. Following implementation, 30-day rehospitalization rates decreased by 27% (from 24.2% to 17.7%), and 60-day rehospitalization rates decreased by 31% (from 22.2% to 15.3%). The structured outreach facilitated early clinical intervention, reinforced individualized care plans, and enhanced symptom monitoring, shifting care delivery from a reactive to a proactive model.

Designed to be low-cost and sustainable, the initiative leveraged existing staff and electronic health record infrastructure. Standardized outreach promoted equitable access for all CHF patients, including those facing socioeconomic or transportation barriers. Overall, proactive telephonic engagement significantly reduced preventable readmissions and improved quality outcomes, supporting scalable chronic disease management in home health settings.

Introduction/Background

Heart failure (HF) remains one of the leading causes of hospital readmissions among older adults in the United States and continues to present significant safety, quality, and financial challenges across the healthcare continuum. Patients with congestive heart failure (CHF) transitioning from acute care to home health are particularly vulnerable to clinical deterioration due to complex medication regimens, fluid management requirements, multiple comorbidities, and limited access to timely follow-up care. Rehospitalizations not only increase healthcare costs but also expose patients to preventable harm, including infection, medication errors, functional decline, and psychological distress.

Reducing avoidable readmissions has been a national priority under the Centers for Medicare & Medicaid Services (CMS), particularly through the Hospital Readmissions Reduction Program (HRRP), which incentivizes hospitals to improve care transitions and post-discharge outcomes. National efforts have demonstrated that structured transitional care and early post-discharge contact reduce readmission risk and improve outcomes (Bradley et al., 2013). Research further indicates that inadequate symptom monitoring, delayed recognition of fluid overload, and poor medication adherence are primary drivers of CHF rehospitalizations (Desai & Stevenson, 2012; Dharmarajan et al., 2013).

Within our organization, internal review of readmission data identified CHF as a leading contributor to 30- and 60-day rehospitalizations in the home health population. Root cause analysis revealed inconsistent early symptom detection, gaps in medication access, and limited proactive follow-up after discharge.

The problem this initiative sought to address was: How can a structured, proactive outreach model embedded within home health operations reduce preventable harm and rehospitalizations among patients with CHF?

To answer this question, the Heart Failure Wellness Call Initiative implemented a standardized, four-week protocol of weekly wellness calls designed to detect early warning signs, reinforce individualized care plans, and intervene before acute exacerbations required hospitalization. This approach builds upon evidence supporting transitional care interventions while adapting the model into a sustainable, equity-focused framework within the home health setting.

Methods

Design:

- Pre-post quality improvement project (2025)
- Compared 30- and 60-day readmissions before vs. after intervention

Population:

- Adults with CHF enrolled in home health within 72 hours of discharge

Intervention:

- 4-week structured wellness call program
- Weekly 10 to 15-minute nurse led calls
- Standardized assessment: symptoms, medications, weights, follow-ups, barriers
- EHR documentation with escalation protocol for red flags

Data & Tools:

- Organizational admission database
- Electronic Health Record (EHR)
- Standardized call template and tracking dashboard

Workflow:

Discharge > Home Health > Weekly Calls (4) > Escalate as needed > Evaluate 30/60-Day Readmissions

Discussion

Interpretation & Significance

Results Interpretation

- 27% reduction in 30-day readmissions
- 31% reduction in 60-day readmissions
- Supports effectiveness of proactive, structured post-discharge outreach
- Demonstrates shift from reactive to preventive care model

Comparison to Literature

- Consistent with prior nurse-led transitional care studies (20–30% reduction range)
- Achieved comparable outcomes without high-cost telemonitoring technology
- Supports scalable, low-cost chronic disease management

Significance

- Improves patient safety and quality outcomes
- Aligns with national readmission reduction priorities
- Promotes equitable access to post-discharge support

Limitations

- Pre-post design (no control group)
- Single-site implementation
- Limited risk adjustment

Future Directions

- Randomized controlled studies
- Long-term sustainability analysis
- Cost-effectiveness evaluation
- Patient satisfaction & quality-of-life measures

Conclusion

Key Findings:

- Structured, proactive weekly wellness calls reduced 30-day readmissions by 27% and 60-day readmissions by 31%.
- Early symptom identification and standardized follow-up improved care coordination and prevented avoidable hospitalizations.
- A low-cost, nurse-led telephonic model can produce meaningful clinical and organizational outcomes.

Contribution to the Field:

- Demonstrates that simple, scalable transitional care interventions can significantly reduce heart failure readmissions.
- Provides evidence that high-cost remote monitoring technology is not required to achieve measurable improvements.
- Supports proactive chronic disease management within home health settings.

Practical Implications & Recommendations:

- Implement standardized post-discharge call protocols for high-risk CHF patients.
- Develop clear escalation pathways for early intervention.
- Leverage existing staff and EHR infrastructure to ensure sustainability.
- Monitor readmission data routinely to guide quality improvement efforts.

Overall Message:

Proactive, structured telephonic engagement is an effective, equitable, and sustainable strategy to reduce preventable harm and improve transitional care outcomes in heart failure patients.

Results

Key Findings

Primary Outcomes:

30-Day Readmissions: Decreased from 24.2% to 17.7% 27%

60-Day Readmissions: Decreased from 22.2% to 15.3% 31%

Statistical Analysis:

Pre-post comparison of proportions
Percentage reduction calculated

Clinical Impact:

Early identification of symptom exacerbation
Improved medication adherence and care coordination
Shift from reactive to proactive care model
Demonstrated scalable, low-cost strategy to reduce preventable harm



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Transforming Diabetes Care: Embedding a Diabetes Nurse Practitioner in Transitional Care to Drive Proactive, Equitable Management

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ABSTRACT

Diabetes is a leading cause of preventable hospital utilization and patient harm, driven by fragmented care, limited access to specialty expertise, and high-risk transitions from hospital to home. At UM Baltimore Washington Medical Center (UM BWMC), diabetes has been the second leading cause of Prevention Quality Indicator (PQI) admissions since 2020, with nearly one-quarter of affected patients experiencing uncontrolled disease. Traditional models assume reliable access to primary care, leaving medically and socially complex patients vulnerable to poor outcomes and repeated acute care use.

To address this gap, UM BWMC embedded a diabetes-specialty Nurse Practitioner (DM NP) within the transitional care clinic to proactively identify and manage high-risk patients discharged from inpatient or emergency department settings. Using real-time electronic medical record (EMR) screening, patients meeting clinical and social risk criteria were engaged during the post-discharge period for medication optimization, diabetes education, technology initiation, and coordinated follow-up.

During the first six months of implementation, patients receiving transitional care DM NP follow-up demonstrated an 80% reduction in total hospital visits, an 84% reduction in admissions, a 33% reduction in readmissions, and a 42% reduction in total charges. All-cause readmissions for diabetes-related encounters declined by 33%.

Embedding diabetes expertise into transitional care improves safety, reduces preventable utilization, and offers a scalable model for equitable chronic disease management.

INTRODUCTION & BACKGROUND

Diabetes affects over 38 million adults in the United States and is a major contributor to cardiovascular disease, kidney failure, amputations, and premature mortality. Nationally, one in four healthcare dollars is spent on diabetes care. At UM BWMC, 30% of inpatients and 40% of ED discharges have diabetes, with uncontrolled disease common among high utilizers. Limited access to primary care and diabetes expertise leads many patients to rely on episodic acute care, particularly during transitions from hospital to home—one of the highest-risk periods for medication errors, care gaps, and readmissions.

This project sought to address the question: *Can embedding diabetes specialty care into transitional care reduce preventable utilization and improve outcomes for high-risk patients?*

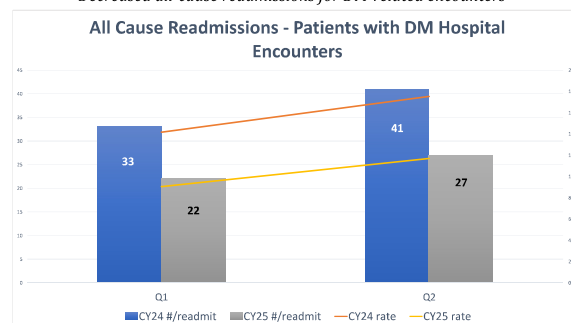
METHODS

This quality improvement initiative targeted adults (≥18 years) with diabetes transitioning from inpatient or ED care. High-risk patients were identified using real-time EMR-based screening criteria, including elevated A1c (>9%), high readmission risk scores, new or intensified diabetes therapy, delayed outpatient follow-up, lack of insurance or primary care, and social barriers.

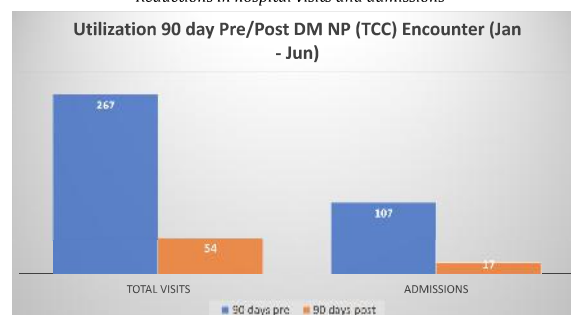
A DM NP embedded within the transitional care clinic conducted post-discharge visits focused on medication reconciliation, therapy optimization, diabetes self-management education, continuous glucose monitor initiation, and coordination with nurse care managers and community health advocates to address social drivers of health. Outcomes were assessed using 90-day utilization and cost data pre- and post-intervention.

RESULTS

Decreased all-cause readmissions for DM-related encounters



Reductions in hospital visits and admissions



Reductions in total charges for patients seen by transitional care DM NP

Pre/Post Time Period	Patients Included for the Time Period	Patients with Case Mix Data for the Time Period	Case Mix Data Available Through
3 Months	A1	A2	Aug. 31, 2025
Visit Type	Visit Summary		
A.			
Visit Type	Pre Total Charge	Post Total Charge	Difference Total Charges
ED	\$ 51,006	\$ 27,456	(\$23,550)
IP	\$ 928,591	\$ 683,749	(\$244,842)
OMC v SS h.a.	\$ 130,875	\$ 22,677	(\$108,198)
OP	\$ 54,570	\$ 11,671	(\$42,900)
Grand Total	\$ 1,125,050	\$ 643,553	(\$481,497)

Reductions in PQIs for patients seen by transitional care DM NP

Pre/Post Time Period by Measure		
Time Period	Total Patients Included in Analysis	% PQI Admits Pre / % PQI Admits Post
1 Month	73	41.46% / 20%
3 Months	60	39.47% / 7.69%
6 Months	31	38.39% / 0%

RESULTS

Among patients engaged by the transitional care DM NP:

- 80% reduction in total hospital visits
- 84% reduction in hospital admissions
- 33% reduction in readmissions
- 42% reduction in total charges

Reductions were observed across ED, inpatient, and observation visits, with a corresponding increase in outpatient care utilization. PQI admissions declined during the same period. All-cause readmissions for diabetes-related encounters decreased by 33% over six months.

DISCUSSION

Embedding diabetes specialty care into transitional care significantly reduced preventable hospital utilization and costs while improving care continuity for high-risk patients. These findings align with existing literature highlighting the importance of timely post-discharge follow-up and specialty expertise for chronic disease management. Addressing social drivers of health alongside clinical care likely contributed to improved engagement and outcomes. Limitations include single-site implementation and short-term follow-up. Future work will evaluate long-term glycemic outcomes and scalability across additional conditions and settings.

CONCLUSIONS

A transitional care model that embeds a DM NP can safely and effectively shift diabetes management from reactive to proactive. This approach reduces hospital utilization, improves equity, and fills a critical gap for patients who lack reliable access to primary care. The model offers a replicable framework for health systems seeking to improve chronic disease outcomes and reduce preventable harm.

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ACKNOWLEDGEMENTS

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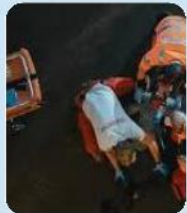
Interagency Collaboration: ICare Program Assists Vulnerable Populations and Reduces Healthcare Overutilization

ABSTRACT

In October 2024, the inpatient Care Management, Emergency Department Navigation, and Community Care Coordination teams began collaborating with the Department of Aging and Maryland Emergency Medical Services (EMS) in Baltimore County to participate in the Integrated, Community, Assessment, Referral and Evaluation (ICARE) Program. The goal of the program is to provide services and resources to meet the needs of vulnerable populations in the community, advancing equity in patient care, and avoiding overutilization of EMS and the emergency department. ICARE was established to address non-emergency needs in the community, or situations where people are calling EMS not because of acute medical emergencies, but because of unmet social, environmental, or health needs. The ICARE program brings together community partners and resources such as housing, mental health, and other social services via a streamlined referral process and has been successful in identifying at-risk and vulnerable individuals. Through the ICARE program we have seen many success stories connecting people to the services they truly need. The decrease in inappropriate or overutilization of EMS also decompresses Emergency Departments allowing more timely service to individuals in need of emergent medical care and ensures that EMS crews are out in the community and readily available to respond to emergencies. By building safety and health equity into this process and taking the extra step to ask, "is there something else going on? Is there another way we can help?" The team has successfully linked adults in the community to the resources and programs they need and in turn decreased overutilization of EMS and the Emergency Department. If we can spread this work to other hospitals in the state, we know there could be a real impact on the overcrowding that plagues Maryland emergency departments.

PROBLEM

The patient safety challenge addressed was the need to respond to patients who would use emergency medical services for non-emergency situations. This was taking valuable resources from our community, contributing to overcrowding the ED, and most importantly- not addressing the root cause of the patient's needs.



Resource Management

Reductions in multi-visits allows for more appropriate utilization of EMS and Emergency services for patients with true medical emergencies

ED Overcrowding

Community based interventions reduce unnecessary hospitalizations and subsequently potential readmissions

Addressing Patient Needs

Most importantly this program has allowed us to connect vulnerable patients to the resources they truly need

METHODS

The Baltimore County ICARE Program maintains a list of multi-visit patients (MVP) whose 911 transports are primarily driven by social, behavioral health, or substance use factors rather than acute medical needs and once identified, the referral process is started. First responders refer patients to the EMS/ICARE Captain, who collaborates with the Public Health Nurse from the Baltimore County Fire Department to connect patients with appropriate county agencies and community resources. On a monthly basis the team:

- Reviews the active MVP list and updates patient status.
- Analyzes data through CRISP and hospital service utilization.
- Determines next steps, including referrals to:
 - Community Care Coordination
 - Ambulatory Care Program
 - ED Navigation Services
- EMS/ICARE team reports on recent 911 utilization.
- Care Management updates on hospitalizations and dispositions.
- Evaluates whether continued intervention or service resolution is needed.

Typical interventions include:

- Develop individualized care plans.
- Adjust treatment logistics (e.g., modifying dialysis schedules to align with patient needs and social support).
- Refer to appropriate services to address medical, behavioral, and social barriers.
- Referrals to Community Care Coordination and ED Navigation
- Placement in alternate levels of care (e.g., assisted living, Skilled Nursing Facility, long-term care)
- Pursuit of guardianship for vulnerable or unrepresented patients
- Mental health and substance use follow-up and referrals
- Engagement with Adult Protective Services, Department of Aging, and related agencies for eligibility screening
- Transportation coordination and mobility assistance
- In-home support services, including therapies and home care nurse/aide
- Enrollment in waiver programs
- Access to food pantries and nutritional support

SUCCESS STORIES

- **Patient A-** 87-year-old female living with sister and mother, but in a basement apartment. The patient and her living situation were in poor condition. Adult Protective Services (APS) was engaged. This patient was able to receive inpatient geriatric mental health services and was transitioned to an Assisted Living Facility (ALF). Utilization of 911 reduced from 87 to 1. No ED visits or hospital utilization since 5/25. Patient had previously been in observation or ED, inpatient 6 times during collaborative period.
- **Patient B-** 82-year-old-female living with a paid caregiver in single family home. Caregiver had difficulty caring for the patient and utilized the hospital for respite. The patient lacked capacity and had multiple medical issues requiring 24/7 care. Long term care was offered, but the healthcare decision maker and caregiver repeatedly declined. The Guardianship process was activated. A court appointed guardian was assigned and the patient was moved to long term care. Transports to the hospital decreased from 29 to zero during the collaborative. Utilization of hospital services was reduced by 60%.
- **Patient C** -51-year-old female with End Stage Renal Disease (ESRD) with multiple visits related to missing dialysis. The patient lives with family who support the patient with transport preparations, but family members also work. There were fifty-three transports prior to program activation, and the patient had accumulated 20 more transports in the last year. The patient had 6 hospital visits in 2024 and 8 hospital visits in 2025. Interventions included referrals to Community Care Coordination. The Nurse Case Manager is communicating with Dialysis Center to change the dialysis schedule to be more compatible with caregiver's work schedule, that ideally improves patient compliance with dialysis. The collaborative hypothesis is that the schedule change could subsequently reduce 911 calls, hospitalizations and potential readmissions. Community Care Coordination continues to provide ongoing support and monitoring. This case continues to be a work in progress that is closely monitored by the team.

IMPACT & VALUE

The ICARE program has proven to be a success and is a collaborative we are very proud of. We are the only Hospital in Baltimore County currently engaged in this partnership. The efforts from this team have not only advanced health equity in our community but also reduced overutilization of precious resources. From October 2024 to October 2025, there was a 79% reduction in active multi-visit patients and a 63% decrease in 911 transports to the emergency department. This reduction results in more appropriate utilization of EMS and emergency department services for patients with true medical emergencies. Appropriate utilization also reduces unnecessary hospitalizations and subsequently potential readmissions through proactive community-based interventions. Most importantly, we have been able to connect vulnerable patients to the resources they truly need.

Metric	October 2024	October 2025	Change/ Outcome
Active Multi-Visit Patients (MVPs)	43 (later increased to 71 total throughout the year)	15 (19 resolved, relocated, or deceased)	75% reduction
ED Transports via 911	1,813	663	63% reduction

3 patients accounted for 544 (36%) of total transports

SUSTAINABILITY

The project results we have seen have motivated the team to provide consistent input to help understand what is working well and what still needs to be solved. There have been many success stories but there is certainly a need to continue collaborating with EMS and community resources to ensure patients are receiving the right care in the right place. If we can help connect patients with the care they need in the community, we can improve health equity in the community and prevent overutilization of our EMS and hospital resources. These efforts align with the AHEAD model launched by CMS Innovation Center whose goal is to improve population health, advance health equity, and reduce healthcare costs.

The success of this collaborative further inspire and motivate us in our journey to Zero Harm, and we continue to work to improve



Presented By:

Maria Manna, Director of Case Management and Utilization Review
Danielle Geier, MSN, RN, Director of Quality Improvement
Executive Champion: Ira Rabin, MD, VP & Chief Medical Officer

Acknowledgements: Craig Carmichael, Brandon Killough, and all members of the collaborative including the Executive Director of Post-acute Services, Manager of Ambulatory Care Coordination, Captain of Baltimore County Fire Department ICARE Program, Public Health Nurse for Baltimore County Fire Department ICARE Program, and Social Work Liaison for Hospital to Home Program with the Baltimore County Department of Aging
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Improving Medication Access for Sexual Assault Patients to Enhance Safety and Patient Satisfaction

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MedStar St. Mary's Hospital

Abstract

This project was initiated to address critical gaps in care for sexual assault patients treated in the Emergency Department (ED). Previously, this patient population was only provided with a 3-day supply of critical medications such as antibiotics, non-occupational post-exposure prophylaxis (nPEP) medications, and supportive treatments. This approach posed significant barriers to timely treatment, especially for vulnerable populations such as individuals experiencing homelessness, those who are incarcerated, or patients living at protected addresses due to domestic violence.

To improve both patient safety and the patient's overall satisfaction of care a new process allowing sexual assault (SA) patients to receive full doses of medications including antibiotics, nPEP medications, and supportive treatments directly with their ED discharge instructions was implemented.

Background

There was a need identified to standardize an order set to streamline medication ordering and dispensing to ensure all patients had the opportunity to appropriate treatment following a sexual assault.

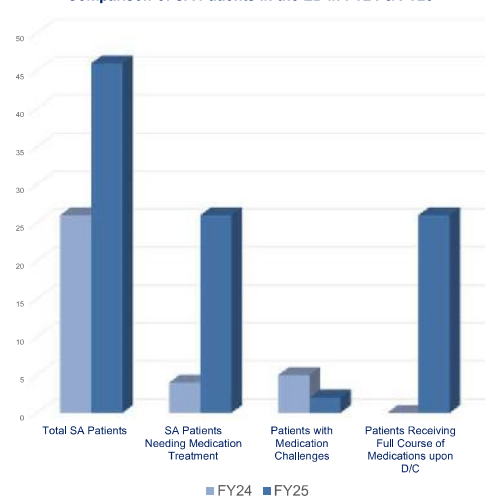
Methods

- "ED SAFE to Go" medication order set was developed and implemented.
- A comprehensive job aid was created to support clinical work flow.
- Targeted education was provided to nurses, pharmacy staff, and ED medical providers to ensure consistent implementation.

Results

The number if SA patients presenting to the ED has increased significantly from FY24 to FY25. While we saw a slight decrease in the number of patients reporting challenges with obtaining a full course of treatment, this number might be inaccurate due to hesitancy in reporting. All patients requiring medications after presenting to the ED for SA received a full course of medications prior to discharge.

Comparison of SA Patients in the ED in FY24 & FY25



Discussion

By transforming the discharge process at its foundation, the innovation became the new standard of care one that is safer, more efficient, and trauma-informed, eliminating the fragmented practices that previously left vulnerable patients at risk. This order set is continuously updated by our Pharmacy team to ensure that we follow the best practices and recommendations by the state of Maryland. This project could be replicated by other hospitals, who offer forensic services, very easily by following our order set options.

SAFE medication kit order set

The order set includes supportive medications, STI treatment, and nPEP medications. The order set gives options for different creatinine clearance levels as well.



Conclusion

With the ED SAFE to Go Medication Order Set, 100% of eligible patients now leave with their full prescribed course at the time of discharge. Early follow-up calls with our community partners revealed a significant decrease in patient reports of missed or incomplete medication use, and patients described the process as "easier and less stressful."

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U.S. Department of Health and Human Services (HHS)

Acknowledgements

A special thanks to all who participated in and supported the development of this practice change for our vulnerable patient populations.

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Acknowledgements: The Emergency Department Team, Northwest Hospital Leadership Team, Craig Carmichael, and Brandon Killough.



Reducing Left Without Being Seen (LWBS) in the Emergency Department

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Background/Introduction

Left Without Being Seen (LWBS) represents a significant patient safety and equity risk in emergency departments. In one of the highest-volume EDs in the state, hundreds of patients were leaving annually without medical evaluation, often still symptomatic and vulnerable to deterioration.

Analysis revealed that prolonged wait times combined with lack of structured reassessment resulted in limited visibility of waiting patients. LWBS was reframed from a throughput issue to a system-level patient safety challenge, requiring redesign rather than individual vigilance.

Methods

- A phased Plan-Do-Study-Act (PDSA) approach was used
- Design Phase
 - Created a dedicated Waiting Room Nurse role
 - Developed structured 2-hour reassessment protocols
 - Implemented standardized communication scripts
- Pilot Phase
 - Deployed role during peak-volume hours
 - Collected real-time patient and staff feedback
 - Refined workflows and protocols
- Expansion Phase
 - Implemented role across all shifts
 - Integrated LWBS, EMS offload, and patient experience metrics into dashboards
 - Established daily huddles and alignment with triage workflows

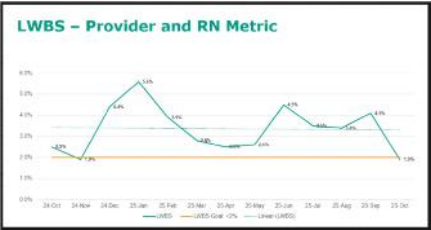
A multidisciplinary team, including patient access, environmental services, and IT, supported workflow redesign and reliability.



Aims

- Reduce LWBS to below 2%
- Improve patient safety and early detection of clinical deterioration
- Enhance patient experience through improved visibility and communication
- Create a reliable, sustainable structure for monitoring waiting patients

Figure 1. LWBS Trend



Results

- LWBS Rate: reduced from peaks >5% to consistently <2%
- Resilience: Rates returned to goal following seasonal volume surges
- Press Ganey Likelihood to Recommend: Increased from 60.54% to 69.24%
- EMS Transfer of Care: Demonstrated gradual improvement with stabilization following workflow changes

Conclusions and Implications for Practice and Future Research

This initiative demonstrated that patient safety begins at the front door, not the bedside. Embedding visibility, reassessment, and communication into standard workflows reduced preventable harm and restored trust.

Implications for Practice

- Waiting rooms can function as monitored care environments
- Safety should be designed into systems, not dependent on individual heroics
- Visibility-focused roles can advance equity and dignity in care

Future Research

- Expansion of visibility-based models to other departments
- Long-term impact on adverse events and patient outcomes
- Evaluation across diverse ED settings

This low-cost, workflow-based model is scalable and replicable without new technology.

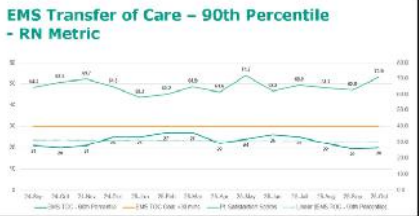


Figure 2. EMS TOC 90th Percentile

A Multidisciplinary Model for Hardwiring Language Equity for Patients with Limited English Proficiency

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Introduction/ Background

- Language barriers can lead to preventable harm through miscommunication, poor discharge understanding, and reduced family engagement
- Language access is not only a patient's safety issue; it is a matter of health equity
- A retrospective review of patient records revealed that interpreter use at discharge was documented in only 24% of Limited English Proficiency (LEP) cases, and just 63% of families received discharge instruction in their preferred language, revealing patient safety and compliance issue
- Workgroup found that inconsistent interpreter use was not due to lack of effort, but to gaps in workflow, technology, and documentation processes
- Interventions were implemented using Plan Do Study Act (PDSA) to make safe communication easier and more reliable for staff

Objectives

- Improve use of interpreter services
- Implement standardized process for accessing interpreter service device
- Improve documentation of interpreter services use at least once a shift and at discharge
- Identify patients with limited English proficiency on admission
- Provide discharge instruction in patient's preferred language
- Promote equitable care for patients with limited English proficiency

Methods

- Peer to Peer, nurse led education provided to all Peds and PICU nurses
- Streamline identification of patients with limited English proficiency with standard image of blue phone on door after identification during admission process
- Increase devices based on data showing there is normally no more than 5 patients on the unit at one time that require interpreter services
- Collaborate with provider team and information services to ensure discharge instructions printed in preferred language
- Multidisciplinary monthly meetings to discuss trends, successes, and barriers
- Monthly audits tracking areas for improvement in nursing and physician processes
- Positive reinforcement acknowledging staff compliant in LEP documentation
- Department level systemization: dedicated discussions of methods to increase interpretation methods with staff during monthly unit-based Professional Governance meetings

Results and Discussion

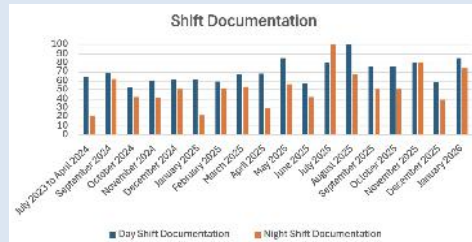
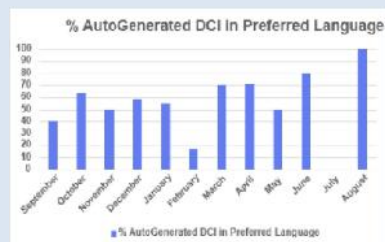
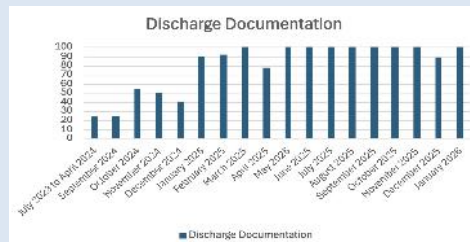
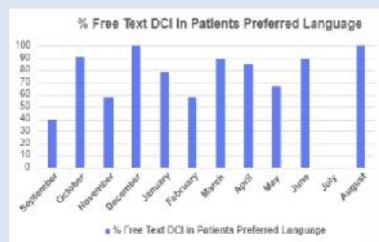
- Interpreter use for Discharge Documentation increased from 24% in September 2024 to 100% in January 2026
- Consistent LEP Documentation for dayshift above 75% since 7/2025
- LEP Documentation for nightshift Sept 2024 increased from 21% to above 50% post-implementation
- Provider discharge instructions improved from 40% Sept 2024 to 80-100% post intervention
- The multipronged approach to increasing use of interpreter services is ongoing working towards unit set goal of 70% of discharge documentation
- Day shift documentation started higher but remains unchanged

Outcomes/ Future Steps

- Updated hospital nursing discharge form to include required fields to streamline interpreter services documentation as of January 2025
- Ongoing interdisciplinary collaboration for additional opportunities for improvement
- Continue to follow interventions for a year to assess compliance
- Identify opportunity for improvement for utilization of interpreter services with agency (travel) and PRN staff
- \$10,000 grant to certify staff to medically interpret another language in collaboration with HR and Legal Team

Strengths/ Limitations

- Strengths: support from institution for improvements in healthcare equity, support of staff to continue initiative, alignment with National Patient Safety Goal 16.01.01
- Limitations: Devices acquired need maintenance or unable to update, patients prefer in person interpreters (staff or family members), and hospital approved interpreters may be inaccurate at times



Reducing Self-Discharge and Hardwiring Safe, Equitable Care in Outpatient Rehabilitation

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Abstract

Non-adherence to outpatient physical therapy (PT) is a widespread patient safety challenge that leads to preventable harm, delayed recovery, and inequitable outcomes. National data indicate that up to 70% of patients do not complete their therapy plans, with underserved populations disproportionately affected. This initiative aimed to reduce early self-discharge, strengthen continuity of care, and embed high-reliability and equity-driven processes into outpatient rehabilitation workflows.

A multidisciplinary team analyzed root causes across clinical, non-clinical, and site-specific domains, identifying gaps in communication, education, scheduling reliability, and EMR-supported workflows. Using these findings, the team developed a high-reliability intervention bundle that included standardized front-desk scripts and checklists, teach-back education to confirm patient understanding, frequency-matched scheduling, rapid outreach following cancellations, and telehealth discharge options to mitigate access barriers. EMR-integrated reports and real-time dashboards supported consistent documentation, early identification of non-adherence risks, and accountability through audit-feedback cycles. DMAIC quality strategy (Define, Measure, Analyze, Improve, Control) used in Lean Six Sigma to improve, optimize, or stabilize existing, underperforming business processes. Following adoption, self-discharge rates decreased from 26.8% to 16.1% (a 39.9% relative reduction). Cancellations declined from 20.7% to 15.3%, and average monthly visits increased by 28.7%. Staff reported clearer workflows and improved confidence in delivering equitable, patient-centered communication. Patients demonstrated enhanced engagement and understanding, with notable improvements among populations facing socioeconomic and logistical barriers.

Embedding reliability-focused processes directly into the EMR and daily operations created a sustainable, low-cost model that advances safety, equity, and continuity in outpatient rehabilitation. This approach aligns with national patient safety priorities and offers a replicable framework for broader outpatient and ambulatory settings.

Introduction/Background

Non-adherence to outpatient physical therapy (PT) is a nationally recognized patient safety and quality-of-care challenge. Across the United States, as many as 70% of patients fail to complete their prescribed PT plans, a trend consistently associated with delayed recovery, increased pain, functional limitations, and preventable complications. Early drop-off—often within the first three visits—reflects gaps in communication, health literacy, scheduling reliability, and system-level processes that disproportionately affect individuals experiencing socioeconomic disadvantage, transportation barriers, and other social determinants of health.

This pattern of non-adherence creates inequitable outcomes, with undeserved populations experiencing higher rates of self-discharge, canceled appointments, and disengagement from care. As a result, patient safety risks increase, clinical progress slows, and overall rehabilitation effectiveness declines. National organizations, including the Joint Commission and the American Physical Therapy Association, emphasize continuity of care, effective communication, and equitable access as foundational components of safe and high-quality outpatient rehabilitation.

To address these challenges, our organization launched a site-level initiative designed to embed safety, reliability, and equity directly into daily PT workflows. By integrating standardized communication processes, teach-back education, EMR-supported prompts, automated follow-ups, and access-focused solutions such as telehealth discharges, this initiative sought to reduce early self-discharge, improve adherence, and strengthen the reliability of care delivery.

This poster presents the problem, the high-reliability interventions implemented, and the measurable improvements achieved across patient outcomes, staff workflow, and system performance.

Methods

Innovation & Systems Solutions

A high-reliability intervention bundle was developed to embed safety, equity, and consistency into routine rehabilitation workflows.

Intervention Components

- **Standardized Communication** - Front-desk scripts and checklists improved accuracy and transparency in patient interactions (AHRQ, 2020).
- **Teach-Back Education** - Clinicians verified patient understanding and documented agreement with the plan of care, strengthening equitable communication (Ha Dinh et al., 2020).
- **Frequency-Matched Scheduling** - Appointment schedules were aligned with clinical recommendations to support continuity and reduce variation.
- **Rapid Cancellation Outreach** - Same-day follow-up promoted re-engagement and reduced gaps in treatment.
- **Telehealth Discharge Visits** - Remote final visits reduced transportation and access barriers for underserved patients (Totten et al., 2022).
- **Audit-Feedback Dashboards** - Visual performance dashboards enabled real-time monitoring and reinforced accountability across staff teams (Ivers et al., 2020).
- **EMR Automation** - Built-in reports, templates, and workflow minimized reliance on memory and promoted reliability through system design.



Aim of the Bundle

To establish a sustainable, site-specific model that embedded transparency, reliability, and equitable care delivery within daily rehabilitation operations.

Interdisciplinary Team Approach

A collaborative, multi-disciplinary structure supported design, testing, and implementation.

Team Roles

- **Rehabilitation Clinicians** - Identified workflow barriers; developed patient-centered education materials and teach-back protocols.
- **Front-Desk & Scheduling Teams** - Co-designed scripts, checklists, and scheduling workflows to reduce errors and standardize communication.
- **Information Technology Specialists** - Integrated dashboards, prompts, and automated fields into the EMR to support real-time tracking.
- **Quality & Safety Teams** - DMAIC strategy (Define, Measure, Analyze, Improve, Control) used in Lean Six Sigma to improve, optimize, or stabilize existing, underperforming business processes.
- **Therapy Leadership** - Alignment with organizational safety, quality, and equity goals while promoting inclusive communication cultures.

Discussion

The high-reliability rehabilitation bundle produced meaningful improvements in patient retention, continuity, and equity. Reductions in self-discharge and cancellations, alongside increased monthly visits, suggest that standardized communication, teach-back, and frequency-matched scheduling strengthened engagement and reduced care fragmentation. Telehealth discharge visits further improved equitable access by reducing transportation and socioeconomic barriers. These system-level gains were reinforced by staff-reported improvements in workflow clarity, reduced burnout, and increased satisfaction—reflecting how EMR automation, scripts, and dashboards shifted reliability from individual memory to system design. The interdisciplinary team structure enabled successful adoption through co-design, DMAIC strategy, and alignment with equity and safety priorities. Overall, the initiative demonstrates that embedding structured, equity-focused processes into routine rehabilitation practice can enhance safety, patient understanding, and continuity of care, supporting alignment with NPSGs and APTA standards.

- **Positive Outcomes:** A high-reliability intervention bundle in outpatient rehabilitation reduced self-discharge, increased care continuity, and improved treatment adherence.
- **Equitable Access:** Telehealth discharge planning reduced access barriers for underserved patients and supported equitable closure of care episodes.
- **System Reliability:** Automation, teach-back, and performance dashboards helped shift reliability from individual effect to system design at site level.

Conclusion

- **Patient Engagement**
Standardized, equity-focused processes strengthened patient engagement and treatment continuity.
- **Staff Experience**
System design improvements reduced cognitive load and increased staff satisfaction.
- **Best Practice Alignment**
Results support alignment with national safety and quality standards.

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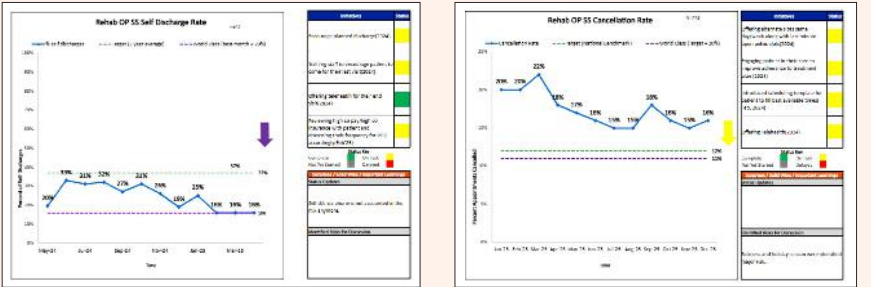
Results

Impact & Outcomes

- Improved Patient Retention and Continuity of Care
- Self-discharge rate decreased from 26.8% to 16.1%
- Cancellations decreased to 15.3%
- Average monthly visits increased by 28.7%

Enhanced Patient Comprehension & Equity

Staff reported better workflow clarity and improved job satisfaction. Patients showed stronger engagement and comprehension, particularly among underserved groups. These outcomes aligned with NPSGs and APTA standards emphasizing equity and continuity of care.





Human Trafficking: Best Practices for Victim Identification and Care

A LifeBridge Health Collaborative

Jessica Wilson, MS, RN, CEN, CPEN, TCRN, NPD-BC, EBP-CH; Molly Anderson, BSN, RN, CEN, PCCN, FNE-A;
Morgan Caldwell, BSN, RN; Joletha Anderson, AA, CHW-Mngr. VRT



Background:

- ~20.9M individuals are estimated to be trafficked.
- 87% of trafficking survivors sought health care but not identified as a victim of human trafficking (HT).
- According to literature available, most emergency department staff don't feel confident in their ability to identify a HT victim and most have never had training on HT.
- LifeBridge Health (LBH) lacked standardized HT screen, procedures and clinician education.

Methods & Implementation

- A literature review was completed in 2023 to identify best practices for human trafficking identification and nursing education for HT screening and identification.
- An LBH Human Trafficking collaborative was developed in June 2024 to design HT Red Flags into Electronic Health Record (EHR) documentation, review escalation pathways, and develop a response procedure.
- The EHR was revised in June 2025 for ED, OB and inpatient units:
 - Implemented a standardized Human Trafficking Red Flags screening process in triage/admission forms.
 - Developed an escalation process to support clinical teams when a HT patient is identified.
- Disseminated Education in June 2025 to include:
 - Didactic and interactive training modules for LBH
 - Simulation with Standardized patients

Electronic Health Record Revisions

- Combined 4 different forms into 1 standardized screening form in which documentation will pull forward to prevent duplicate questioning of the patient by various team members.
- Reference text added to support the nurse in identification of HT, abuse and neglect red flags/indicators.
- Escalation pathway updated and aligned for LBH.

Standardized Patient Simulation- Competency Review

- In December 2025, the Sinai and Grace ED teams participated in a Human Trafficking Standardized Patient Simulation in which 2 females entered the ED, one seeking care for abdominal pain, prompting the ED clinical team to assess the situation with the goal of identifying HT red flags and separating the patient from the trafficker.

A total of 38 simulations were completed with a **92% success rate** for HT identification and a **74% success rate** for patient separation.

"The Simulation actors were so realistic!"

"I really enjoyed the standardized patient simulation for a real time scenario review"

"I have always been worried about my ability to ID a human trafficking patient, but this was great practice!"



Sustainment and Future Planning

- Policies and Procedures were updated to include Human Trafficking screening and escalation practices.
- Collaboration with Center for Hope and LBH Violence Response teams established for case reviews and continued education for case reviews and continued education
- Education updated and assigned annually and on-hire.
- Continued community engagement and partnership with S.A.F.E. centers.
- Next Steps:
 - Design a report to capture the total incidence of human trafficking screening and/or positive screens.

Conclusion

- In response to the global crisis, LifeBridge Health has taken a comprehensive, system-wide approach to strengthen HT identification and response.
- Through the development of a multidisciplinary collaborative, implementation of a standardized screening tool and escalation pathways, and robust clinician education, LBH has improved staff confidence and capability in identifying HT victims.
- These efforts position LBH to better protect vulnerable patients and advance the standard of care in human trafficking identification.

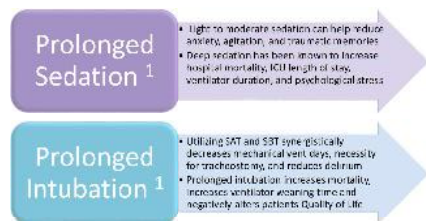
Human Trafficking Hotline: 1-888-373-7888

References:

Available Upon Request

Background

In the Cardiac Intensive Care Unit (CICU), ventilated patients were not consistently screened for Spontaneous Awakening Trials (SATs) and subsequent Spontaneous Breathing Trials (SBTs). To counteract risks associated with prolonged sedation and intubation¹, the CICU team identified the need for a standardized and collaborative SAT SBT procedure that harmonized nursing and respiratory therapy to encourage timely mechanical ventilation liberation.



Aim of the Project

Increase the compliance of daily SAT and SBT to 95% between March and November 2024, as measured by satisfaction surveys provided to Registered Nurses (RNs) and Respiratory Therapists (RTs), and chart audits.

Methods

Sample/Population:

- Nursing (n=36) and Respiratory Therapists (n=50)

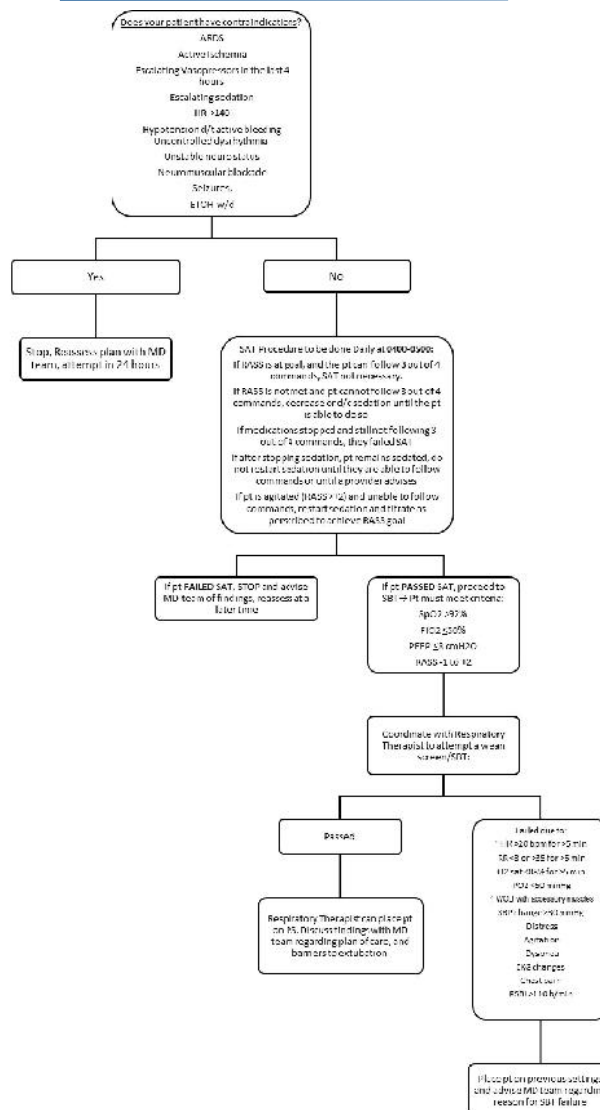
Intervention:

- In February 2024 a multidisciplinary workgroup was formed (administrators, RNs, RTs)
- In February 2024, a user-friendly flowchart was developed based on hospital protocol to guide SAT and SBT initiation
- On March 25, 2024 (Go-Live Date), RNs initiated SATs between 0400-0500, documented results, and communicated with RTs, who then performed a 1-min wean screen and documented the outcome.

Data Collection:

- Chart Audits- patient identified as eligible or contraindicated for SAT/STB; weekly reviews beginning May 2024
- Surveys- Distributed post implementation to RNs and RTs (8 questions) Likert-Scale (1= very poor, 5=excellent) to evaluate satisfaction, confidence, and perceptions of collaboration

SAT/SBT Flowchart



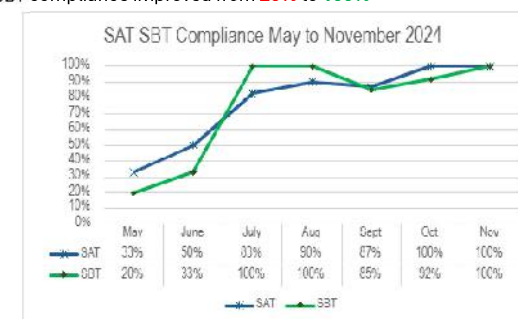
Results

Survey Results:

- 74% of RNs and 60% of RTs who participated rated the communication amongst the teams to have risen to *very good* and above

Chart Audits:

- Patients were consistently identified as appropriate for SAT and SBT or contraindicated.
- SAT compliance improved from **33%** to **100%**
- SBT compliance improved from **20%** to **100%**



Discussion/Implications

- Standardizing the SAT/SBT process improved compliance and highlighted the importance of structured RN-RT collaboration
- Closed loop communication between RNs and RT was essential for achieving 100% compliance

Future Study

- Future studies should include a pre-survey to establish baseline perceptions of collaboration amongst staff.
- **Surveys** should also be distributed simultaneously for direct comparison

Reference Material



Reducing mechanical ventilation using an evidence-based bundle with a focus on delirium

Jasmyn Berkley MSN, RN, FNP-C

Kristin Seidl, PhD, RN

Brooke Vacovsky, DNP, RN, AGCNS-BC, EBP-C

Abstract

Problem: In 2024, the average length of mechanical ventilation (LOMV) in a medical ICU at a level II community hospital was 4.2 days, exceeding the 3.5-day benchmark. Delirium assessment and management were also inconsistent. Evidence supports the ICU liberation (ABCDEF) bundle in improving delirium outcomes, ventilation duration, and ICU length of stay. **Purpose:** This quality improvement project aimed to reduce LOMV by implementing the ABCDEF bundle, with a focus on delirium prevention and management. **Methods:** The bundle was implemented over 15 weeks in Fall 2025. Stakeholders were engaged prior to implementation. All intubated ICU patients were included, and the bundle—particularly CAM-ICU assessments—was incorporated into multidisciplinary rounds. **Results:** CAM-ICU completion and delirium intervention documentation each reached 64%, while full bundle compliance was 32%. By the final weeks, delirium screening and interventions achieved 100% compliance. The LOMV decreased to 3.45 days in the final month. **Conclusion:** Implementation of the ABCDEF bundle improved delirium assessment and management and was associated with a reduction in mechanical ventilation duration.

Introduction/Background

Purpose Statement

The purpose of this quality improvement project is to decrease the LOMV among adult medical inpatients in the intensive care unit by implementing the ABCDEF bundle and improving delirium assessment, prevention, and management.

Research has shown that implementing this bundle reduces hospital mortality, decreases the incidence of delirium, minimizes the use of physical restraints, and shortens the duration of mechanical ventilation.

Methods

Process Measures

- The number of CAM-ICU assessments documented per day per patient.
- The number of delirium interventions completed on each patient per shift.
- The number of ABCDEF bundles reported in rounds per day per patient.

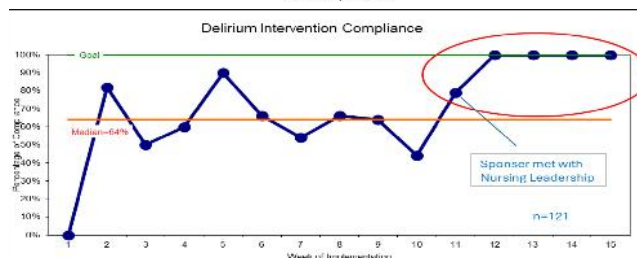
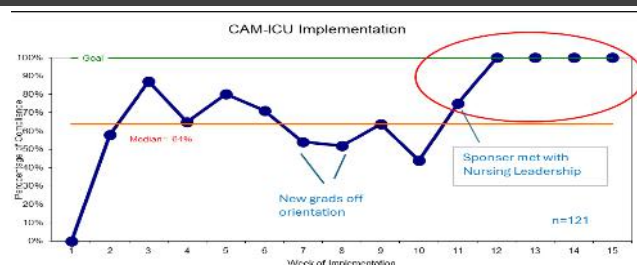
Outcome Measure

- The monthly average of LOMV for the unit

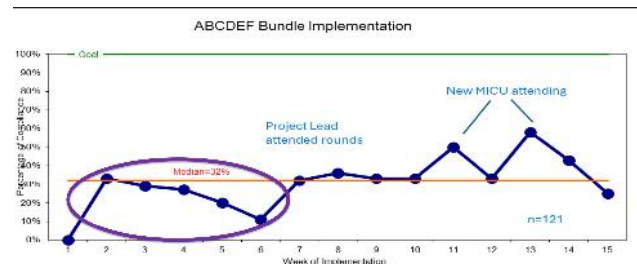
Data Collection & Analysis

- Daily IT-generated reports identifying eligible patients and compliance metrics
- Weekly audit data entered into REDCap
- Process measures calculated as proportions
- Outcome measured as average LOMV
- Descriptive statistics used to evaluate trends over time

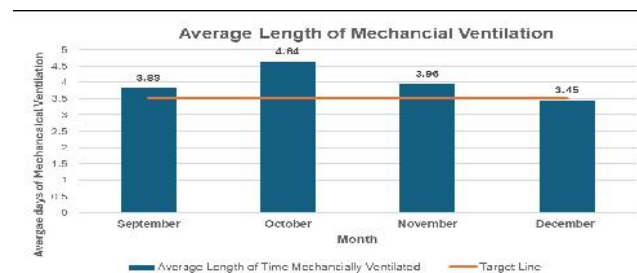
Results



By project end, delirium screening and use of mitigating interventions reached 100%. This trend began in week 11 following ICU leadership intervention.



A decreasing trend was identified from week 2 through week 6, demonstrating that this process measure was not solely dependent on nurses.



Barriers/Limitations

- Variability in ICU team schedules resulted in variation in the multidisciplinary rounding process, preventing early adoption of ABCDEF bundle review.
- Variability in engagement among the night shift, with all components of the project, decreased the weekly implementation rate.
- Short timeframe for implementation.

Discussion/Conclusions

- This project reinforces that structured, consistent delirium screening using the CAM-ICU and implementation of at least two patient-specific delirium interventions per shift can be operationalized within routine care.
- Periods of improved ABCDEF compliance coincided with reductions in LOMV.

Leadership engagement impact:

- Consistent with the literature, increased participation from ICU nursing leadership resulted in sustained improvement during the final five weeks.

Impact/Implications for Practice:

- This project demonstrates that delirium prevention is a critical lever for ventilator liberation and highlights the role of nursing leadership and interdisciplinary engagement in sustaining evidence-based practice change.

Sustainability

- The CAM-ICU has been added to the electronic health record task list to embed into nursing daily practice.
- The nursing professional governance council will begin oversight of this practice.
- The CAM-ICU will be added to the bedside shift report to improve peer-to-peer accountability.
- The ABCDEF bundle education will now be included during ICU orientation.
- Multidisciplinary rounds will be standardized to include the ABCDEF bundle.

References/Acknowledgments



Thank you to the ICU staff, Chezelle George, and Sohonnell Saunders, MHA,BSN,RN.

Non-Pharmacological Management of Orthostatic Hypotension in Ischemic Stroke Patients in Inpatient Rehabilitation

Laura Steakin, Anthony Manfredo, Christine Wang, Demelio A. Urbano, Alexis Huesgen, Amy Voiland, Ilana Tuchman, Mackenzie Weber, Dorothy Wortham

ABBEL Research Division, Rehabilitation Institute at Sinai, Sinai Hospital of Baltimore, Baltimore, MD

Introduction

- **Orthostatic Hypotension (OH):** Positional drop in blood pressure (SBP ≥ 20 or DBP ≥ 10) with sitting or standing, in addition to being symptomatic¹
- **Problem:** OH can limit participation in rehabilitation therapy and slow recovery, particularly in inpatient rehabilitation settings²
- **Development:** Recent literature²⁻¹⁵ on non-pharmacological interventions for OH management
 - Mixed results exist on effectiveness of interventions
 - No clear guidelines on recommended interventions



Primary Aim

A multidisciplinary team (nurses, physicians, and therapists) developed a protocol for managing OH with non-pharmacological interventions in patients recovering from ischemic stroke in inpatient rehab.

Protocol¹⁶

- **Inclusion Criteria:**
 - Patients seen from 03/2024 to 03/2025
 - Had acute ischemic stroke
- **Exclusion Criteria:**
 - Diet limiting PO fluid intake (thickened liquids, tube feeds or NPO)
 - Lower extremity amputees
 - Currently on dialysis
 - Pre-existing OH treated with medication
- **Interventions:**
 - Compression: TEDs, ABD binders
 - PO Bolus: 480 mL water over 5 minutes
 - Exercise protocol detailed in Figure 2
- **Outcomes Tracked:**
 - Toleration of standing activity
 - Toleration of seated activity
 - Unable to tolerate



Protocol (cont.)

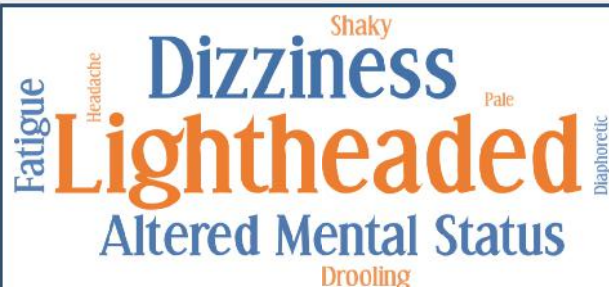


Figure 1. Word cloud display representing the most common symptoms in ischemic stroke patients with orthostatic hypotension, with larger font indicating more people impacted

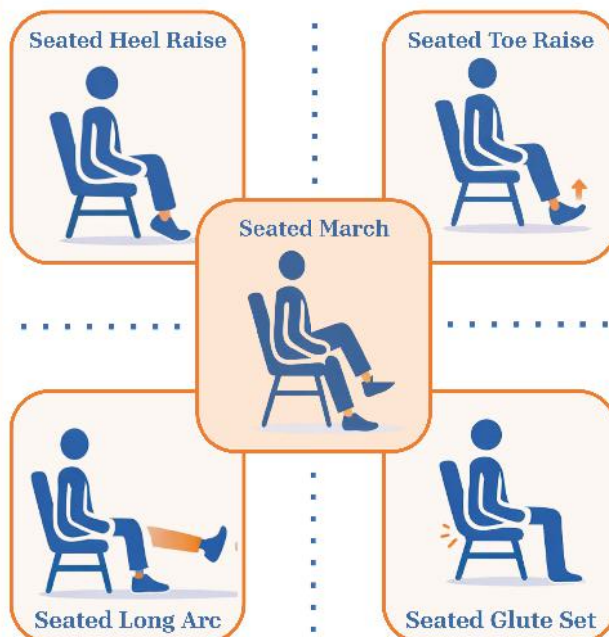


Figure 2. Non-pharmacological exercise protocol used in patient sample with orthostatic hypotension

Results

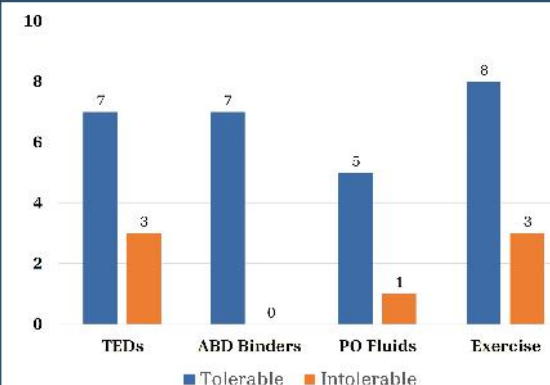


Figure 3. Activity tolerance following non-pharmacological interventions for orthostatic hypotension

Primary Conclusion

This protocol was effective for managing OH in patients with ischemic stroke, contributing to a reduction in missed therapy sessions and improved participation in rehabilitation.

Discussion

- This quality improvement project established a protocol that provides a standardized and timely intervention for orthostatic hypotension (OH)
- Findings show that non-pharmacological interventions can support stabilization of OH that otherwise may limit activity tolerance
- It can be inferred that improving activity tolerance thus reduces patient fall risk and improves safety
- Future large-scale studies could be conducted using the protocol, along the entire continuum of care



REFERENCES

Reduce Hospital Acquired Pressure Injuries in the Progressive Care Unit and Intensive Care Unit at the Cecil Campus of Christiana Care by 20% in FY2025

Lorrinda Lockard, MSN, RN-BC, CWOCN
Donna Buettner- Hartsoe, BSN, RN
ChristianaCare, Cecil, MD



INTRODUCTION

Pressure injuries result in 60,000 deaths annually (1) with an estimated mortality rate of 41 patients for every 1000 (2), accounting for \$9.1 to \$11.6 billion in costs to the U.S. health care system each year (3).

Christiana Care Zero Harm Council estimated the cost of stage III or higher, including deep tissue pressure injury (DTPI) hospital acquired pressure injuries is estimated to be **\$22,377.00**. The Pressure Injury Elimination (P.I.E.) initiative supported Christiana Care's Fiscal Year (FY)2025 annual operating plan for Christiana Care Union Hospital by improving the preventable harm rate.

PURPOSE/AIM STATEMENT

The P.I.E. initiative at Christiana Care Union Hospital was launched to reduce hospital-acquired pressure injuries (HAPIs) through interprofessional collaboration and system-level integration of best practices. The intended goal was to reduce HAPI in the Progressive Care Unit (PCU) and the Intensive Care Unit (ICU) at Christiana Care Union Hospital by 20% in FY2025.

BACKGROUND

Over a 36-month period, baseline data monitoring revealed a significant concern regarding the incidence of HAPIs at the Christiana Care Union Hospital campus, particularly within the ICU and the PCU. The ICU and PCU are critical care areas addressing the needs of high-risk patients. The leading admission diagnosis on both units consist of: congestive heart failure, respiratory failure and stroke. In the FY2023, a total of 34 HAPIs were recorded, with 21 incidents occurring in these units. In the subsequent FY2024, the total number of HAPIs decreased to 24, with 20 incidents occurring in the ICU and PCU. With the goal of pressure injury reduction, in FY2024 both units decided to begin their journey to P.I.E. In addition to having a higher rate of injury, it was also identified that the posterior pelvis (sacrum, buttocks, sacral/coccyx, perianal) and heels were the areas of largest concern.

KEY MEASURES/GOALS

Photo documentation, on admission, transfer and every Wednesday to identify patients at high risk for HAPIs to promote early pressure injury identification/treatment.

Primary Goal:

- Reduce Hospital Acquired Pressure Injuries in the Progressive Care Unit (PCU) and Intensive Care Unit (ICU) at the Christiana Care Union Hospital by 20% by the end of FY2025

Secondary Goals:

- Reduce the number of sacral and heel HAPIs in the ICU and PCU

Secondary Goal 2:

- Support the FY2025 Strengthen the Core- Annual Operating Plan: Christiana Care Union Hospital

Measure: Weekly monitor of pressure injury prevention measures, chart audits, R21, and real time rounding. Weekly auditing of Wound Wednesday sacrum and heel photographs.

METHODS

In March 2024, unit leadership, skin champions, quality and safety teams, and Wound, Ostomy, and Continence nurse (WOCN) initiated a 60-day pilot program aimed at enhancing the focus on HAPI prevention through targeted education and use of Camera Capture.

Safety and equity were hardwired into care processes through several strategies. Direct care nurses drove success via the Wound Wednesday Program, ensuring consistent sacrum and heel imaging at admission, transfer, and weekly intervals. Critical skills education equipped all Registered Nurses (RN) with competencies in skin assessment, device offloading, and proper use of prevention devices, reinforced by hands-on demonstrations. Skin assessments became a standing agenda item during multidisciplinary rounds (MDR), embedding prevention into daily workflows. System level integration was strengthened by skin champion nurses conducting audits across shifts, providing real-time feedback, and ensuring compliance. The WOC nurse supported early intervention through targeted rounding and education. Environmental Services was educated on preserving prevention devices, reinforcing organizational commitment to resource stewardship. MDR templates were redesigned to include skin integrity discussions, ensuring individualized prevention plans. Interprofessional engagement extended to respiratory therapy, nutrition, and rehabilitation teams, addressing device-related risks, nutritional adequacy, and mobility needs. Clinical leadership and the Clinical Nurse Specialist reinforced accountability through routine audits and immediate corrective actions. The initiative leveraged Lean Six Sigma define, measure, analyze, improve and control (DMAIC) methodology to analyze data, identify barriers, and implement sustainable solutions. Unit-based action plans and monthly HAPI team meetings ensured continuous monitoring and improvement. Key takeaways for spread and adaptability were met by having built-in safety strategies that were embedded into workflows (e.g., MDR templates, audit tools) rather than added as optional tasks.

After the 60-day pilot was complete the decision was made to make it a consistent practice for both units.

RESULTS

Targeted interventions led to a 29% reduction in FY2024 (24 HAPIs) and further improvement in FY2025, achieving a 33.3% reduction in PCU and 63.6% in ICU, culminating in a campus-wide reduction of 37.5%.

Christiana Care Union Hospital Statistics

FY	HAPI Campus TOTAL	# ICU HAPI	# PCU HAPI	Posterior Pelvis	Heels	Total % of HAPI
23	34	11	10	7	5	67.8
24	24	11	9	11	2	83.3

Christiana Care Union Hospital HAPI Reduction goal of 20% in FY2025

FY	HAPI Campus TOTAL	# ICU HAPI	# PCU HAPI	Posterior Pelvis	Heels	Total % of HAPI
24	24	11	9	11	2	83.3
25	15	7	8	8	3	50%
	37.5% Reduction for FY25	63.6% Reduction for FY25	33.3% Reduction for FY25	63.6% Reduction for FY25	50% Reduction for FY25	

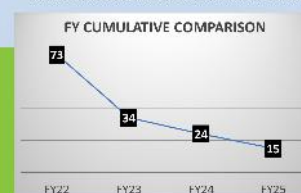
PCU FY2025 results demonstrated a 50% reduction in HAPIs of the posterior pelvis. There was a 50% increase in HAPIs of the heel, however this helped us identify a stronger education and monitoring need.



ICU FY2025 results demonstrated a 71.4% reduction in HAPIs of the posterior pelvis. Heel HAPI's remain zero for this unit for 2 consecutive years.



79.45% Reduction in HAPIs since FY2021



DISCUSSION

Success was driven by shared accountability across nursing, rehabilitation therapy, respiratory therapy (RT), nutrition, and environmental services. Combined with continuous data measurement and feedback loops that enabled rapid response and sustained progress. To foster innovative change, we found it important to look further outside of the bedside nursing care and create this multidisciplinary initiative. Ongoing competency training and peer-to-peer feedback fostered a culture of safety and equity. Key interventions included the Wound Wednesday program for routine imaging, critical skills training for RNs, multidisciplinary rounds, and skin champion rounding with real-time feedback. Additional measures involved introducing new offloading devices, respiratory-led education to prevent device-related injuries, and specialist support through WOC nurse rounding and clinical leadership audits. Interprofessional collaboration extended to providers, nurses, RT, rehabilitation therapy, pharmacy, nutrition, and environmental services, ensuring comprehensive care. Using Lean Six Sigma DMAIC methodology, monthly team meetings reviewed data and guided improvement. Ultimately, the P.I.E. initiative demonstrates that integrating prevention into routine care, supported by education, multidisciplinary engagement, and data-driven strategies can significantly reduce harm and improve patient outcomes. These practices are scalable and adaptable for organizations seeking to eliminate pressure injuries and advance equitable, safe care.

Path forward: ICU and PCU will continue the practice of photo documentation and expanding educational opportunities. They will also continue to perform photos of the sacrum and heels on admission, transfer, and Wound Wednesday.

In FY2026, our Medical Specialty Unit (MSU) and Surgical Specialty Unit (SSU) will be adopting certain aspects of the pressure injury elimination plan.

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- (2) Internet Citation: References. Content last reviewed May 2023. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/hai/pfa/haccost2017-ref.html>
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Sub-Epidermal Moisture (SEM) Scanner for Early Detection and Prevention of Pressure Injuries

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University of Maryland Upper Chesapeake Medical Center



Abstract

Objective: Sub-epidermal moisture (SEM) is indicative of a stage 1 pressure injury and incipient pressure ulcer before visual indicators. Early identification of patients at increased risk of pressure injuries can prompt preventative interventions that reduce the incidence of hospital-acquired pressure injuries. This study evaluated the effectiveness of a SEM Scanner device in the prevention and management of pressure injuries.

Method: The one-month trial study will be conducted on the UCMC unit 5T Oncology. Patients meeting study criteria will have regular visual and daily SEM Scanner skin assessments over the sacrum and heels. SEM readings ≥ 0.6 are indicative of a pressure injury that requires nursing to employ preventive measures. Nursing assessments, SEM scanner results, and preventative interventions will be recorded in electronic medical records. Assessments, scanner results, interventions, and patient outcomes will be tabulated. Nursing staff will also be surveyed for SEM scanner's ease of use.

Results: There were 576 SEM scans on 147 patients. 78% (n=115) had an elevated SEM ≥ 0.6 , indicating a stage 1 pressure injury on admission, 50% of which (n=69) did not have any visual skin indicators. SEM readings ≥ 0.6 by location were 61% sacrum, 36% left heel, 39% right heel. Patients with SEM readings ≥ 0.6 who had one site was 50% (n=50), two sites were 32% (N=47), and three sites were 12% (n=18). None of the 147 patients in the trial developed a Hospital Acquired Pressure Injury (HAPI).

Conclusion: The SEM Scanner allowed for scientific evaluation of the site, which allowed earlier recognition of stage 1 pressure injuries, allowing for earlier preventative interventions resulting in zero HAPIs.

Background:

UCMC had 111 Hospital-acquired pressure injuries (HAPI) in 2024, and 95 YTD in 2025. In 2025, 70% of reported HAPIs occurred outside the ICU (n = 76). UCMC pressure injury prevalence – 1.4 per 1000 patient days of admission. UCMC Unit 5T has 14 HAPIs YTD. In FY2025 71% of HAPIs occurred in the sacrococcygeal (n = 43) or heel (n = 28) anatomical locations.

The Financial Burden

During FY2025 there were 71 sacrococcygeal & heel HAPIs (13 reportable to OIG)

71 HAPIs = \$21,767 (avg. cost to treat) = \$1,554 to treat HAPIs
Projected legal liability cost of 11 HAPIs = \$1,629
Total estimated financial cost of HAPIs = \$3,183

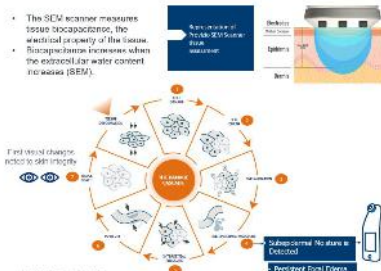
Source: UCMC, National Healthcare Cost Report Survey (NHCERS) data

Projected Treatment Costs	Projected Liability Costs
1. Direct costs	1. Direct costs
2. Indirect costs	2. Indirect costs
3. Total costs	3. Total costs
4. Total costs (including indirect costs)	4. Total costs (including indirect costs)
5. Total costs (including indirect costs and legal liability)	5. Total costs (including indirect costs and legal liability)
6. Total costs (including indirect costs, legal liability, and patient care)	6. Total costs (including indirect costs, legal liability, and patient care)
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Materials:

Provizio SEM Scanner

How it Works



Methodology

Setting: UCMC, Unit = 5T Oncology

Fiscal Year	Total Unit HAPIs for 5T
2025	15
2024	11
2023	8
2022	9

Observation Period: August 1, 2025, to August 31, 2025

Inclusions:

- Adults admitted or transferred to 5T during the 30-day observation period
- Patients without PIs to the sacrum or heels on admission
- Braden of 18 or less

Exclusions:

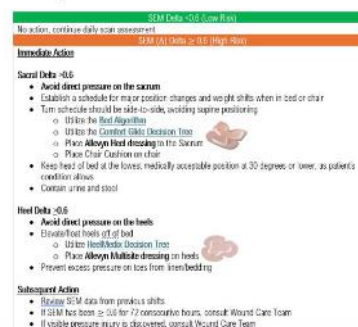
- Patient with any stage of PI to the sacrum or heels on admission
- Patients admitted outside the observation period
- Hospice and pediatric patients

Procedure:

- Upon admission/transfer to 5T, all eligible patients are scanned (sacrum and heels)
- Patients with an elevated SEM delta (≥ 0.6) received targeted PI prevention interventions
- Patients with a Braden score of ≤ 18 or patients with a Braden score ≥ 18 but a delta ≥ 0.6 were rescanned daily until transferred off the unit or discharged

SEM Scanning Protocol

If abnormal readings are noted (SEM delta ≥ 0.6), initiate pressure injury prevention interventions per the SEM Scanning protocol.



Root Causes



Results

SEM Sensor 5T Trial			
Total SEM Scanner Contacts	Sacral Scanner Results	Left Heel Scanner Results	Right Heel Scanner Results
576	150	171	255
SEM Delta ≥ 0.6	95	105	150
SEM Delta ≥ 0.6	63	75	105
SEM Delta ≥ 0.6	32	30	45
SEM Delta ≥ 0.6	15	15	25
SEM Delta ≥ 0.6	8	8	15
SEM Delta ≥ 0.6	4	4	8
SEM Delta ≥ 0.6	2	2	4
SEM Delta ≥ 0.6	1	1	2
SEM Delta ≥ 0.6	1	1	2

- Of the 147 admission/transfer scans performed, 78% (n=115) of patients had at least one delta ≥ 0.6 . This equates to a possible 115 opportunities to identify a pressure injury as present on admission (if the site evolved). One area with an elevated delta = 34% (n=50), two areas = 32% (n = 47), and three areas: 12% (n = 18). The remaining 22% (n=32) were scanned as within normal limits on admission.
- Of the 115 admitted with an elevated delta, 50% (n=69) did not have any visible redness in the sacrum or heels. 61% of elevated deltas were on the sacrum. 36% left heel elevated. 39% right heel elevated.
- Admission race demographics: Caucasian = 82% (n=121), Person of color = 18% (n=26).

Zero HAPIs occurred during the trial period

Estimated Cost Savings

- At a 50% expected reduction in HAPIs, we could...
 - Expect to see \$772K in savings due to cost avoidance.
 - Preserve ~\$211K in reimbursement revenue.
 - (high SEM on admission = POA coding)
 - Predict a potential legal liabilities savings of ~\$60k.
 - Overall net savings of \$650K.
 - For every \$1 spent, return would be \$1.64.

Based on the body of evidence, bruinBiometrics would expect a 50% reduction in PI's using the SEM scanner. At a low moderate incidence rate (1.5 per 1,000 admissions) the **Net Savings at...**

- 50% would be \$496K and the ROI would be 126%
- 60% would be \$649K and the ROI would be 164%
- 70% would be \$800K and the ROI would be 202%
- 80% would be \$952K and the ROI would be 241%

Ease of Use

- 75% to 100% of RNs (n = 24) agreed or strongly agreed with all statements on the "Ease of Use" survey.
 - Questions
 - The scanning procedure was easy to perform.
 - The on-screen interface was intuitive and user-friendly.
 - I was able to complete scans within a reasonable time frame.
 - The training provided was sufficient to begin using SEM scanner confidently.
 - The SEM scanner can fit well into my existing patient care workflow.
 - I know how to intervene when the SEM delta is ≥ 0.6 .
 - The device supports timely decision-making for pressure injury prevention.
 - I am satisfied with the overall use of the SEM scanner.
 - The SEM scanner helps me protect patients from pressure injuries better.
 - I would recommend the SEM scanner to other nursing professionals.

Conclusions:

- Allowed earlier identification than that of visualization of Stage 1 pressure injuries, allowing for earlier treatment and prevention of reportable stages of injuries
- Admission scanning allowed for the identification of Community Acquired Pressure Injuries (CAPIs), decreasing hospital liability
- Nursing staff were able to adopt scanning into the workload and allowed staging of preventative measures
- Patients became engaged with their scanning numbers, thus partnering with care



MedStar Health

Championing Evidence-Based Practice: A Collective Approach to Reduce HAPI

Abby Brzezinski MSN, RN; Karen Droter MSN, RN, CENP
MedStar Good Samaritan Hospital

Problem

The impact of a hospital acquired pressure injury is complex and includes reduced quality of life for the patient, longer hospital stays and decreased hospital reimbursement by the Center for Medicaid Services (CMS).

Background

From July 2023 to June 2024, MedStar Good Samaritan Hospital (MGSH) experienced an increased rate of hospital-acquired pressure injuries (HAPI). In evaluating the HAPI events, gaps focused on pressure injury education, identification of pressure injuries, and application of preventative interventions.

Methods

A Plan-Do-Check-Act (PDCA) quality improvement framework was used to reduce hospital-acquired pressure injuries (HAPIs). Monthly retrospective reviews of HAPI cases are conducted with Nursing Directors and unit-based Skin Champions to identify opportunities for prevention and improvement. For each identified HAPI, a 3-day look-back review is completed to assess contributing factors. In cases of advanced-stage HAPIs, a Root Cause Analysis (RCA) form was completed to guide targeted interventions.

Interventions

- Use of a turn clock (Figure 1) to prompt staff to reposition patient and document position changes.
- Weekly skin rounds on the intermediate care unit with a Nursing Director and skin champions to ensure pressure injury prevention and appropriate interventions are in place.
- A HAPI Triad Team, a multidisciplinary group comprising a wound care nurse, a critical care nursing director, and a critical care provider—was established to review complex cases, oversee prevention efforts, and support staff education.

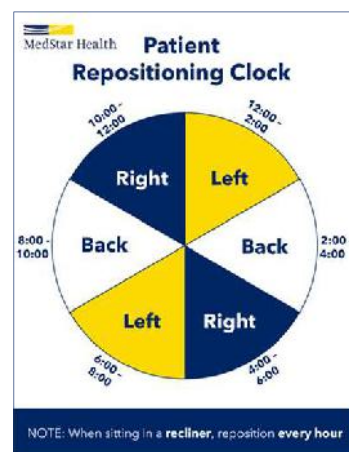


Figure 1- MedStar Health Patient Repositioning Clock

Results

As a result of the collaborative effort, MGSH noted a reduction in HAPI including a 50% reduction in advanced stage HAPI (Stage III, IV, and unstageable). These collaborative efforts enable and facilitate cross-disciplinary education, enhancing the effectiveness of prevention strategies across the hospital.

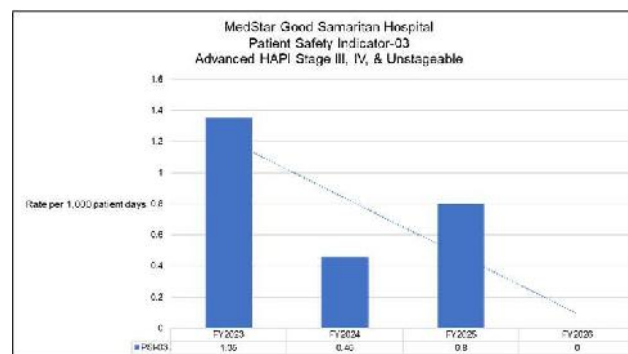


Figure 2- MGSH Advanced HAPI Rate per 1000 patient days.

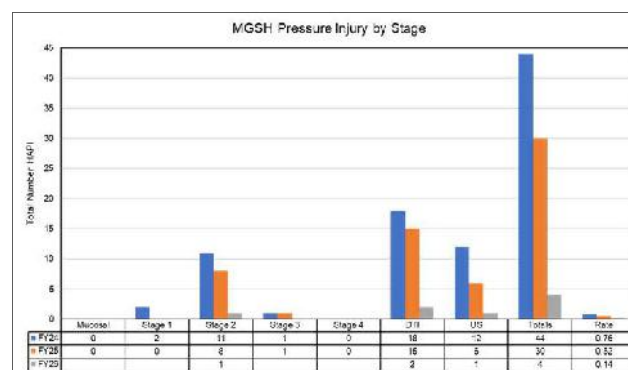


Figure 3- MGSH HAPI # by Stage and rate reduction by fiscal year.

Conclusion

After evaluating an increase in hospital acquired pressure injuries (HAPI) at MGSH, the active engagement of our clinical teams in partnership with our unit-based skin champions and Wound Ostomy Continence Nurses led to a reduction of HAPI.

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Acknowledgements

MGSH Wound Ostomy Continence Nurses and MGSH Skin Champions

THE GUT GUARDIANS

REDUCING C.DIFF



1. ABSTRACT:

Over the past three years, Carroll Hospital implemented a comprehensive, evidence-based quality improvement initiative aimed at reducing *Clostridioides difficile* infections (also referred to as C. diff or CDI). Through a coordinated, multidisciplinary approach and sustained organizational commitment, the project achieved a 44% reduction in C. diff, significantly improving patient safety, strengthening clinical outcomes and reducing avoidable healthcare costs.

2. INTRODUCTION / BACKGROUND:

C. diff is a significant patient safety concern that contributes to prolonged lengths of stay and increased healthcare costs. C. diff is a highly transmissible, spore-forming bacterium that thrives in healthcare environments and disproportionately affects hospitalized patients who are elderly, immunocompromised or receiving broad-spectrum antibiotics. The project aims to strengthen prevention practices, reduce transmission risk and enhance early detection and appropriate management to safeguard vulnerable populations.

CARROLL HOSPITAL
A LifeBridge Health Center **CARE BRAVELY**

AUTHORS: Colleen Hordesky, RN, BSN, CEN, CIC
Kristy Tenney, RN, BSN, CIC

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3. METHODS:

To understand the drivers of harm, the team used the **DMAIC** methodology to **Define, Measure, Analyze, Improve and Control** our processes, which enabled us to conduct a structured root cause analysis using multidisciplinary input from clinical staff, infection prevention, environmental services, pharmacy and quality leaders.

Through review of event data and frontline interviews, the team identified underlying contributors that were not immediately visible, such as inconsistent gaps in antibiotic prescribing oversight and unclear triggers for early testing and containment. The team embedded prevention into everyday workflows, ensuring sustainability and reducing dependence on individual vigilance. Key tactics included:

- **Antimicrobial Stewardship Expansion:** Strengthened guidelines for high-risk antibiotics and provider education to reinforce appropriate prescribing.
- **Improved Flowsheet and Protocols:** A new GI flowsheet was implemented in our medical record for quick view.
- **Staff Education & Competency:** Performed review of open orders daily and provided outreach to nurse managers, providers and staff to reinforce best practices and create local accountability.

4. RESULTS



5. DISCUSSION

As a result of these interventions, the hospital realized a sustained and statistically significant decrease in C. diff infections. Data transparency played a critical role in driving results. Monthly unit-level dashboards, leadership rounds and frontline staff huddles fostered a culture of ownership and continuous improvement. The engagement of senior leadership ensured consistent resources, visibility and organizational alignment.

6. CONCLUSION:

This project not only met but exceeded its goals, positioning the hospital as a leader in infection prevention, as demonstrated by state SIR rank improvement from 26 in Q1 2022 to 13 in Q2 2025, which does not reflect the continued improvement achieved over the course of FY2026. Most importantly, it reflects our collective commitment to delivering safe, high-quality care for every patient, every time.

7. ACKNOWLEDGEMENTS:

Special thanks to the entire Infectious Disease Committee, including nursing and physician leadership, operational excellence, quality, pharmacy, case management, education, EVS, infection prevention, and more for their efforts to promote awareness and remove barriers on our journey to zero harm.



MedStar Health

Executing Multidisciplinary Strategies to Lower Central Line Blood Stream Infections and Enhance Quality

Alfonza J. Riley, MCS, BS, RN, RVS, VA-BC & Pina Patel, MLS (ASCP) SM CM, CIC

MedStar Southern Maryland Hospital Center

Introduction

Central line-associated bloodstream infections (CLABSI) are among the most significant and costly healthcare-associated infections, with profound implications for both patient outcomes and healthcare resources. On average, the direct healthcare cost per CLABSI case ranges widely, with typical estimates between \$25,207 and \$55,001 per case (Yu et al., 2023). Beyond the economic burden, these infections are associated with increased morbidity, prolonged hospital stays, and thousands of deaths annually.

Research has shown that disparities based on race and socioeconomic status significantly influence outcomes for patients with CLABSI. Black African American patients and those covered by Medicaid face higher rates of infection, extended hospitalizations, and greater healthcare expenditures compared to other groups (Mielke, N., Walters, R. W., & Ahmad, F., 2025). This further confuses the overall cost and care burden of a CLABSI.

Methods

A multidisciplinary task force—including infection preventionists, providers, case managers, vascular access nurses (VAD), clinical specialists, and hospital leadership—revised CLABSI prevention bundles and implemented consistent compliance tracking.

This team then met weekly meetings for high-risk patients. Patients who met the following criteria were considered high risk:

- Central line accessed more than 2 days without a positive blood culture on admission.
- Positive cultures nearing the end of the 14-day repeat infection window.
- Permacath in place for over 90 days.
- Ports accessed for more than 2 days inpatient.
- Femoral line placements.

Methods (cont.)

Team Responsibilities:

- Infection Preventionists: Lead weekly reviews, provide patient histories, assess line indications and cultures and maintain the active patient list.
- Nursing Leaders: Assess dressing integrity, evaluate CHG or alternative bathing adherence, and complete compliance audits.
- VAD Nurses: Recommend line alternatives per INS, AVA, and MAGIC guidelines and coordinate with vendors for product evaluation.
- Clinical Specialist: Daily rounding to ensure care and maintenance bundles compliance.
- Providers: Manage inpatient and discharge care plans and issue real-time orders.
- Case Managers: Coordinate discharge planning and care continuity.

Results

Since October 2024, no new CLABSI events have occurred. As of January 1, 2026, more than 500 patients have been reviewed through this process, with 80.3% follow-up compliance. Discharge coordination has improved, and no rise in readmissions was detected. The CLABSI rate prior to implementation was 2 CLABSI's per year. Post-implementation, the CLABSI rate decreased to 0.0, which has been sustained to date.

Sustainability, Spread and

Replicability

Aligned with the CMS Hospital-Acquired Conditions (HAC) Reduction Program, this work highlights the effect of multidisciplinary engagement on patient safety. Over a year later, maintaining a zero CLABSI rate emphasizes that consistent collaboration, transparency, and communication drive sustainable change. This innovative, resource-conscious strategy demonstrates that weekly high-risk reviews, combined with shared digital workspaces and empowered engagement, can be replicated across varied healthcare settings to significantly reduce infection risk.

Limitations or next steps

Our limitations include constraints related time conflict for team members to attend all meetings, and data collection was difficult to obtain, and process related to our present EMR system.

Conclusion

This innovative, resource-conscious strategy demonstrates that weekly high-risk reviews, combined with shared digital workspaces and empowered engagement, can be replicated across varied healthcare settings to significantly reduce infection risk.

References



Acknowledgements

We would like to acknowledge all the members of the Multidisciplinary team. Especially Jennifer Bierbaum, DNP, APRN-CNS, Dr. Chiledum Ahaghotu, MD, Pina Patel, MLS, Infection Preventionist, and all members of the Vascular Access Team.

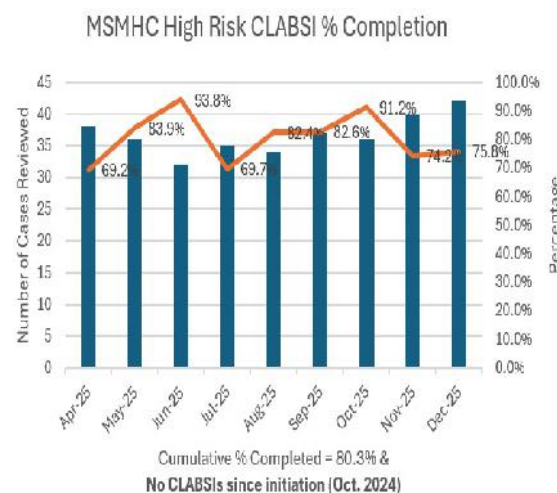


Figure 1
MSMHC High Risk CLABSI Percentage Completion from October 2024 through December 2025

Using High Reliability Principles to Eliminate CLABSI at Ascension St. Agnes Hospital

Presenters:

Wendy Lincoln MBA, MSN, CMSRN, NEA-BC, FACHE
Sarah Warwick, BS, RN
Ascension St. Agnes Hospital

Introduction/Background

Between July and December 2024, Ascension Saint Agnes Hospital identified a cluster of 8 CLABSIs, including a cluster of ICU cases. CLABSIs are associated with:

- Increased mortality
- Prolonged hospital length of stay
- Increased antibiotic resistance
- Higher healthcare costs
- Poorer patient and family experience

Purpose/Aims

High Reliability Principles were implemented with the **goal of achieving zero CLABSI**. High Reliability Organizations maintain strong safety records in complex healthcare environments.

The following principles were implemented across the hospital:

- **Preoccupation with Failure** - Continuously identifying small failures before they lead to larger problems
- **Reluctance to Simplify** - Examining issues closely to identify underlying root causes, often within the system
- **Commitment to Resilience** - Anticipating failures and creating processes that prevent recurrence

Methods

High Reliability Principles were implemented through the following interventions:

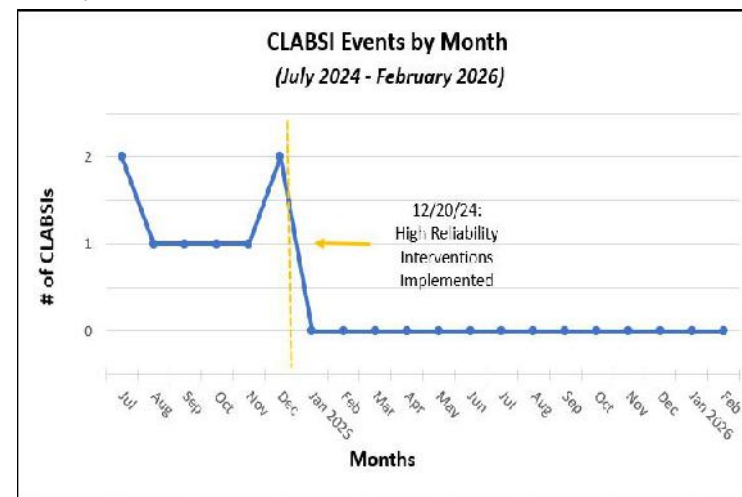
- Leadership rounded on all patients with central lines before 0800 to assess bundle compliance
- Bundle compliance fallouts were tracked and reported during the 0800 Nursing Huddle and 0930 Safety Huddle
- A standardized dressing change day (Wednesday) was implemented.
- All non-critical care dressings were changed by the Vascular Access Team
- The Vascular Access Team audited 100% of inhouse central lines three times weekly
- Mini RCAs conducted for all CLABSIs to identify root causes and guide interventions
- CHG-impregnated caps placed on all lines
- Dialysis ports no longer used for medication administration; pigtails used instead

Conclusions

High Reliability Principles enabled the identification of system-level gaps, implementation of targeted interventions, and achievement of zero CLABSIs hospital-wide while supporting sustained safer practices.

Results

Following implementation, **zero CLABSIs** were reported in both the ICU and hospital-wide from **January 2025 through March 10, 2026**. The hospital also **achieved one full year without a CLABSI** in January 2026.

[illegible]

OB NAVIGATION PROGRAM ANALYSIS

HOW REVIEWING A PROGRAM CAN IMPROVE QUALITY & SAFETY

ABSTRACT

This project redesigned the Obstetric Navigation program to deliver safe, reliable, and equitable care across pregnancy and postpartum. Standardized workflows reduced duplicative tasks and improved consistency, especially for high-risk patients. Safety enhancements included escalation processes for suicidal ideation and stronger coordination with community resources. Outcomes included improved efficiency, earlier identification of perinatal mood symptoms, and increased resource connection, demonstrating how system-level design enhances patient safety and equitable care.

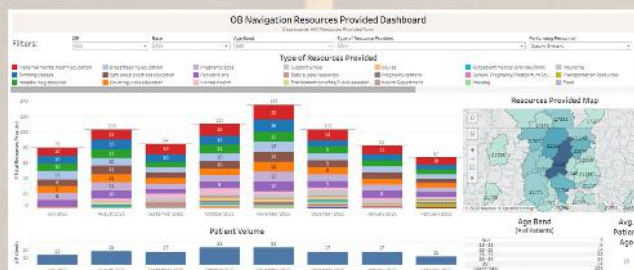
BACKGROUND

The perinatal and postpartum periods are high-risk, requiring timely connection to critical resources. Prior to this initiative, outreach lacked standardized workflows, resulting in duplicated tasks, inconsistent follow-up, and excessive manual tracking that limited direct patient care. Pregnant and postpartum patients - especially first-time parents and those with social needs - were at risk for gaps in support. Standardization was essential to ensure consistent outreach, improve access to community resources, and promote equitable, safe maternal care.

METHOD

A gap analysis and process map identified key issues, including duplicative documentation, unclear ownership, inconsistent workflows and limited resource tracking. The program was redesigned to embed safety through standardized outreach criteria, structured prenatal and postpartum workflows, defined escalation pathways and improved data tracking. Implementation included new process maps, resource tracking tools, revised call structures, clear staff roles and multidisciplinary collaboration to enhance efficiency, consistency, and patient safety.

Prenatal Phone Call Process



RESULTS

Qualitative improvements include significantly reduced duplication of tasks, more time allocated to direct patient care, increased tracking of connection to community resources, increased provider awareness of the program, and improved reliability of the OB Navigation role using structured check-ins.

Staff report improved workflow efficiency and clearer expectations. Patients with complex needs are more reliably reached out to and connected to services, decreasing the likelihood that issues escalate without support.

ON THE HORIZON

Standardized workflows and role guidelines are now embedded to ensure long-term sustainability, supported by ongoing multidisciplinary oversight. Future efforts include refining the resource-tracking tool to measure completed referrals and implementing a formal policy for managing suicidal ideation identified during outreach. This model is scalable to other hospitals through structured workflows, data tracking, and community partnerships, aligning with state and national priorities for maternal mental health, follow-up, and equitable access to care.

BRITTANY OSBURN, LCSW-C, OB NAVIGATOR

PRESENTED BY:

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The Sustained Impact of a Multifaceted CLABSI Prevention Program

Kirk Huslage, MSPH, BSN, RN, CIC, FAPIC, Nkechi Mezu, MSN, RN, CNL, Uzoamaka Obiekwe, MPH, MLS(ASCP), CIC, Sarah Stanley MSN, RN, CNL, EBP(CH)

Significance

- Central line associated bloodstream infections (CLABSIs) contribute substantially to patient harm through increased mortality, prolonged hospital stays, and higher healthcare costs.
- In Maryland, CLABSI rates are publicly reported and influence reimbursement through value-based programs, increasing urgency for sustained prevention.
- The persistent burden of preventable infections signaled a need for a new approach to both diagnostic stewardship and central line management.

Apparent Cause Understanding

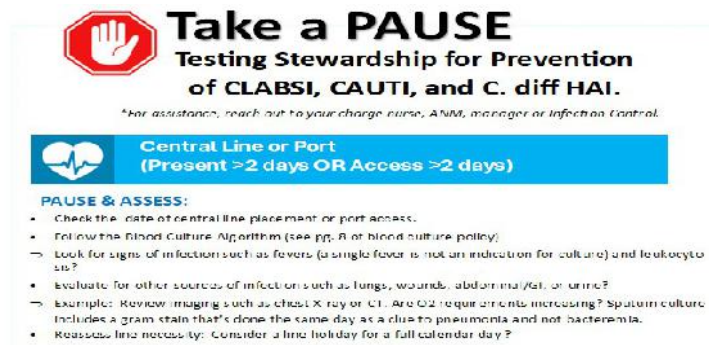
- Review of internal data revealed that 92% of blood cultures showed no growth, mirroring national findings that only 5–10% of cultures are positive.
- Diagnostic stewardship deficiencies were linked to 6 of 10 CLABSIs in FY23.
- Apparent Cause Analyses revealed that inappropriate pan-culturing for vague symptoms was a key contributor.

Innovations

- Creation of a multifaceted diagnostic stewardship model combining algorithm guidance, EMR integration, and nurse-provider collaboration.
- The Purposeful Pause- a novel, structured moment for interdisciplinary evaluation before initiating blood cultures.
- Leveraging a national blood culture bottle shortage as a catalyst to accelerate systemwide algorithm adoption.
- High-touch collaboration between Infection Prevention and frontline nurses enabling real-time consultation and culture review.

Implementation Approach

- Implementation of a single-set policy for blood cultures..
- A 72-hour hard stop in the EHR to prevent unnecessary repeat cultures.
- Restriction of clearance cultures to cases of *S. aureus* bacteremia or *Candida* fungemia.
- Distribution of laminated quick-reference cards to ensure easy algorithm access.
- Integration of the algorithm into EHR PowerPlans for seamless ordering and workflow alignment.



Take a PAUSE
Testing Stewardship for Prevention of CLABSI, CAUTI, and C. diff HAI.

**For assistance, reach out to your charge nurse, ANM, manager or infection control.*

Central Line or Port
(Present >2 days OR Access >2 days)

PAUSE & ASSESS:

- Check the date of central line placement or port access.
- Follow the blood culture algorithm (see pg. 8 of blood culture policy).
- Look for signs of infection such as fevers (a single fever is not an indication for culture) and leukocytosis?
- Evaluate for other sources of infection such as lungs, wounds, abdominal/GI, or urine?
- Example: Review imaging such as chest X-ray or CT. Are GI requirements increasing? Sputum culture includes a gram stain that's done the same day as a clue to pneumonia and not bacteremia.
- Reassess line necessity: Consider a line holiday for a full calendar day?

Outcomes

- Achieved a 92% reduction in CLABSI infections, from 13 infections (SIR 1.1) in FFY2019 to 1 infection (SIR 0.1) in FFY2025.
- As of October 30, 2025, our hospital has achieved one-year CLABSI free!
- Blood culture volume decreased 27% (2023–2025)



Sustainability

- Support through strong interdisciplinary collaboration
- Routine central line discussions during bedside and multidisciplinary rounds
- Consistent frontline coaching and consulting from Infection Prevention and Clinical Excellence teams
- IP rounding and real-time feedback reinforce best practices and promote accountability.
- Leadership prioritization and recognition programs



Acknowledgements

The Sinai Clinical Excellence Team, Infection Prevention Team, Unit Leadership and Nursing staff, Information and Technology Department, the Chief Medical Officer and Ordering Providers

WHEN TEAMWORK MAKES THE DREAM WORK

HOW THE CREATION OF A QUALITY MANAGEMENT COLLABORATIVE IMPACTED MATERNAL HEALTH AND THE HEALTH OF A HOSPITAL

D Drive Strategy

Develop and deploy service-line specific tactics that contribute to the success of Carroll Hospital.

R Regulatory Readiness

Ensure operations meet regulatory requirements and are in an ever-ready state for reporting and visits.

E Evidence-Based Practice

Cultivate a culture of curiosity where all are encouraged to challenge current state and seek best practice.

A Analysis & Improvement

Use our Performance Playbook to review performance, analyze opportunities and hardwire improvements.

M Multi-Disciplinary Collaboration

Foster mutual support and accountability – regardless of position, experience or hierarchy.

1 Abstract

Maternal health outcomes have become a growing concern nationally and in Maryland, where maternal morbidity rates continue to rise. Ineffective communication among healthcare professionals is a leading contributor to medical errors, highlighting the need for stronger multidisciplinary collaboration. In October 2023, we created a multidisciplinary perinatal quality management collaborative, including nursing, providers, educators, quality advisors, senior executives, and more to address maternal health trends and improve patient safety. By shifting from siloed work to a culture of collaboration and accountability, the initiative improved engagement and clinical outcomes and promoted sustainable safety practices.

2 Introduction / Background

The group began by reviewing our quality dashboard for opportunities and selected our NTSV c-section rate as our first project. **The national target for NTSV is 23.6% – we peaked at 56%, which meant more than half of our first time moms had c-sections.** Reducing our NTSV rate would prevent potential complications, lower healthcare costs, and lead to better outcomes for both mother and baby. It was through this work that our hospital established its service line approach – **DREAM Teams** – which is an acronym for the objectives to the left.

3 Methods

We chose to use the **DMAIC** methodology to **Define, Measure, Analyze, Improve, and Control** our processes, including the following:

- Included team members who aren't always invited to family birth meetings, such as senior executives and operational excellence, who looked at our issues differently than our clinicians, helping us create more effective, sustainable solutions.
- Completed a Single Case Bore analysis by auditing each event to identify the most common reasons for the c-section. These causes fell into 3 general categories: fetal heart rate issues, labor issues and fetal size/position.
- Used a Fishbone diagram to identify actionable tactics:
 - Implemented a Pre-Cesarean checklist for labor dystocia/failure to progress to ensure that a c-section was not done prematurely.
 - Provided education and visual reminders to chart Bishop scores to indicate favorability for induction.
 - Changed who was first call during the night shift to promote more active labor management.
 - Started inductions earlier in the day in the hopes that they would be more effective.
 - Encouraged earlier amniotomy to promote labor progress.

4 Results: NTSV C-Section Rate



5 Discussion

We have achieved both measured and unmeasured improvements in patient outcomes. Beyond the numbers we have created a culture of collaboration and better communication. We hold huddles at least twice a day to review the plan of care for our patients. Nurses are empowered to speak as colleagues. Providers are more engaged. Team members recognize that improving patient safety requires looking at processes more than at individual people. The collaborative is a safe way to identify risks and create solutions as a team.

6 Conclusion

This collaborative worked to eliminate preventable harm by changing the culture of the team and by improving communication across disciplines. Getting key stakeholders together around the same table in the presence of senior leadership demonstrated the importance of patient safety, communication and collaboration. It helped change our culture as we worked together for better outcomes. The collaborative also provided a template for others in any area of healthcare to use and as a result of our success, similar DREAM Teams for each service line will be created.

7 Acknowledgements

Special thanks to the entire Family Birthplace Quality Management Collaborative DREAM team, including CNO Leigh Chapman, CMO Dr. Mark Olszyk, Ex Dir Brett Kane, Ex Dir of OpEx Emily Miller, Dir Quality Cathy Primrose, and Quality Imp Specialist Cindy Harris for their efforts to promote awareness and remove barriers.



EMBEDDING EQUITABLE BEREAVEMENT CARE INTO PATIENT SAFETY SYSTEMS

ELIZABETH O'DONNELL, MPH (C)
FOUNDER OF AALIYAH IN ACTION

A LITERATURE-INFORMED IMPROVEMENT FRAMEWORK FOR PERINATAL LOSS

BACKGROUND AND PATIENT SAFETY GAP

Approximately 1 in 175 pregnancies in the United States ends in stillbirth, yet bereavement care following pregnancy or infant loss remains highly variable and inconsistently addressed across hospital systems (CDC, 2023).

Families frequently report fragmented communication, limited emotional support, and inequitable access to culturally responsive care, contributing to preventable psychological harm and diminished trust in healthcare institutions (Koopmans et al., 2013; Gold et al., 2019).

Research demonstrates that poorly managed bereavement experiences are associated with long-term mental health morbidity and increased distress among both patients and clinicians (Heazell et al., 2020; Meaney et al., 2021). Despite these risks, bereavement care is rarely framed as a patient safety issue, and no national standard exists to guide consistent, equitable responses following perinatal loss.

PROBLEM STATEMENT

Perinatal bereavement care is inconsistently delivered across hospital settings, resulting in preventable emotional harm and inequitable patient experiences following pregnancy or infant loss.

IMPLICATIONS FOR PATIENT SAFETY

Bereavement care is a critical, underrecognized patient safety issue

System-level design reduces reliance on individual clinician effort

Equity must be intentionally embedded into care processes

Improvement frameworks support reliable, compassionate care delivery

FROM IDENTIFIED GAPS TO SYSTEMS- LEVEL IMPROVEMENT OPPORTUNITIES

Identified Gap	Patient Safety Risk	Improvement Opportunity
Inconsistent Bereavement Response	Preventable Emotional Harm	Standardized Work Flows Post Loss
Limited Staff Guidance	Provider Distress & Variability	Trauma-Informed Trainings
Inequitable Care Experiences	Disparities in Patient Trust	Culturally Responsive, Anti-Racist Response Designs
Reliance on Individual Effort	Inconsistent Care Delivery	System-designed, Reliable Care Practices

EARLY INSIGHTS AND EVIDENCE INFORMED INSIGHTS

Bereavement care following perinatal loss varies widely across hospital settings

Evidence links inconsistent communication to preventable emotional harm

Equity gaps persist for marginalized families after perinatal loss

PROPOSED IMPROVEMENT FRAMEWORK

Standardization of bereavement response processes

Trauma-informed communication principles

Anti-racist and culturally responsive practices

Integration into existing clinical workflows

Iterative learning aligned with improvement science principles

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Meaney S. et al. Women and Birth, 202



MedStar Health

Right Route, Right Time: Leveraging Pyxis Alerts to Prevent Administration Errors

Harriet Kusi, PharmD, MBA, BCPS
MedStar Georgetown University Hospital

INTRODUCTION

- Medication errors can occur at any point in the medication-use process, from prescribing to administration.¹
- An estimated 8%–25% of hospital medication errors occur during the administration phase.²
- Wrong-route administration poses a high risk of morbidity and can result in serious harm or death.³
- Between April 2023 and October 2024, seven wrong-route events were reported at MGUH involving IM trimethobenzamide and dicyclomine administered IV.

This initiative aimed to:

- Reduce wrong-route errors involving IM trimethobenzamide and dicyclomine
- Reinforce correct route of administration at the point of dispensing
- Implement a sustainable, system-level safeguard using technology

RESULTS

Figure 1: Pyxis Alert



Real-time alert at point of removal

Figure 2: Workflow with Pyxis Alert

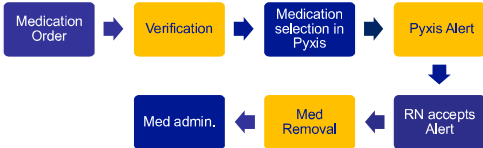
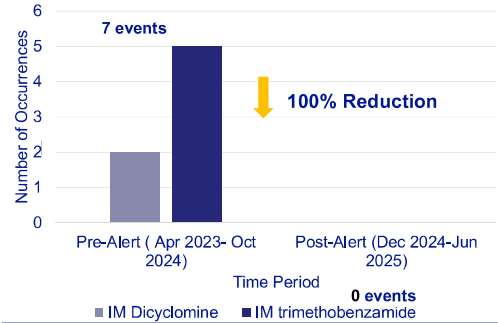


Figure 3: Wrong Route Events: Pre vs. Post Alert Implementation



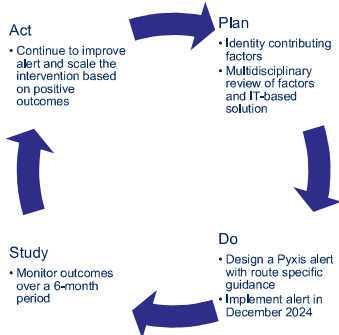
Time Period	IM Dicyclomine	IM trimethobenzamide	Total
Pre-Alert (Apr 2023-Oct 2024)	0	7	7
Post-Alert (Dec 2024-Jun 2025)	0	0	0

Wrong-route administration events dropped from 7 to 0 following implementation of route specific Pyxis alert in December 2024.

METHODS

- A root cause analysis, including a Fishbone diagram, was conducted to identify contributing factors to wrong-route administration errors.
- A Plan-Do-Study-Act (PDSA) approach guided the design, implementation, and evaluation of the intervention.





DISCUSSION

- Alerts placed at **point of medication removal** align with workflow and reduce reliance on memory
- Integration into existing systems minimized disruption and improved adoption
- Findings support use of technology-enabled safeguards for high-risk medications
- Limited to single site and specific medications; broader evaluation needed

CONCLUSION

- Implementation of targeted Pyxis alerts eliminated wrong-route errors over the evaluation period.
- Real-time alerts at point of removal improve medication safety.
- Intervention is scalable to other high-risk medications

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Beyond the Scope: Redefining Patient Experience in Endoscopy

Standardizing Communication, Comfort, and Follow-Up to Improve Patient Experience and Outcomes

Sarah Brace, MSN, RN, NE-BC and Sanmeet Singh, MD

100% Procedure +
Anesthesia Info Metrics



77% increase in Likelihood to
Recommend



12% increase in Press Ganey
& CG-CAHPS

**Emotional safety was treated as a partner to clinical safety by embedding compassion and clarity into standard workflows*

Abstract

A patient experience initiative was implemented in a high-volume endoscopy unit at Luminis Health Anne Arundel Medical Center (LHAAMC) to improve communication, comfort, and post-procedure support. Standardized, workflow-integrated interventions resulted in measurable improvements in patient satisfaction, communication, and likelihood to recommend, demonstrating a scalable model for patient-centered procedural care.

Background

Patients undergoing endoscopic procedures frequently experience anxiety, uncertainty, and discomfort, often driven by inconsistent communication, limited emotional support, and variable care processes. These challenges are amplified in high-volume procedural environments and among pediatric patients and their families, who require additional reassurance and tailored support.

As procedural demand increased within the LHAAMC Endoscopy Unit, there was a need to develop a model that balanced operational efficiency with individualized, patient-centered care. Prior workflows lacked standardization in communication, comfort measures, and post-procedure follow-up, resulting in variability in the patient experience.

This initiative aimed to redesign care delivery by embedding equity, communication, comfort, and emotional safety into routine clinical workflows.

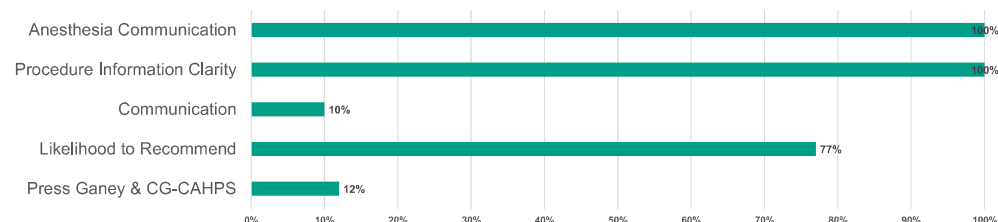
Methods

A unit-based patient experience initiative was launched in January 2025 and fully implemented by April 2025 using a systems-based, workflow-integrated approach.

- Standardized bedside scripting to set expectations
- Structured post-procedure callback process
- Real-time patient rounding and feedback capture
- Enhanced family communication touchpoints
- Comfort-focused interventions (warm blankets, music, individualized supports)
- Pediatric-specific enhancements (gowns, distraction tools, pediatric-trained staff)
- Staff education and reinforcement through daily workflows
- Leadership rounding to ensure adherence and feedback
- Multidisciplinary engagement (nursing, technicians, providers, anesthesia, patient experience)

Results

Following implementation, the Endoscopy Unit demonstrated measurable improvements in patient experience metrics:



Discussion

This initiative demonstrates that patient experience can be significantly improved through intentional workflow design and standardization, rather than relying solely on individual staff performance. By embedding communication, comfort, and follow-up into routine care processes, variability was reduced and emotional safety was elevated alongside clinical safety.

Importantly, the model supported both adult and pediatric populations, addressing a key gap in procedural care. The integration of structured follow-up and real-time feedback created a continuous improvement loop, reinforcing accountability and sustainability.

These findings highlight the importance of treating patient experience as a core component of quality and safety, particularly in high-throughput procedural environments.

Conclusion

Embedding standardized communication, comfort measures, and post-procedure support into endoscopy workflows resulted in measurable improvements in patient experience outcomes. This initiative demonstrates a scalable and sustainable model for integrating equitable, patient-centered care into procedural settings.

The approach is highly replicable across other procedural and perioperative environments and aligns with national priorities in patient experience, safety, and quality.

“The experience was great, everyone was so kind and helpful. Thank you for making this as easy as it could be”

“My daughter’s team was absolutely incredible, above and beyond. I was so impressed with the Pediatric GI care at AAMC.”

“Throughout the entire hospital experience, "spa day" kept bubbling up in the back of my mind... Every single member of the team made me feel like my wellbeing was all that mattered.”

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Interdisciplinary Nursing and Provider Joint Mock Codes: Enhancing Early Code Response and Team Performance

Krupa Patel¹, Grace Corry¹, Ashley Haas², Beth Milchling², Carrie Outten¹, Crystal Silbak¹, Kristina Hoerl², Lara Street¹, Paula Murray², Peggy O'Leary¹, Salem Hernandez¹, Shelby Cahill², Tijana Tuhy¹, Stephen Berry¹

¹The Department of Medicine, Johns Hopkins Hospital, Baltimore, Maryland

²Nursing Professional Practice and Development Specialists, Johns Hopkins Hospital, Baltimore, Maryland

Background

In 2024, safety event reports in the Department of Medicine at The Johns Hopkins Hospital identified critical gaps in cardiac arrest ("code") response. Key findings:

- Delays in rhythm interpretation
- Inconsistent use and understanding of the automated external defibrillator (AED)
- Ineffective interdisciplinary (nurse/provider) communication and role clarity

Nursing and providers complete separate trainings, but no interdisciplinary mock codes exist.

Project Aim

Provide interdisciplinary mock code training for nurses and providers working together, with scripted scenarios that focus on critical actions during the initial moments of cardiac arrest.

Description of the Intervention

Educational scripts and scenarios were used for consistency and focused on:

- AED use and timing
- Cardiopulmonary resuscitation (CPR) choreography/role assignment
- Closed-loop communication

Trained facilitators conducted unannounced mock codes on four general medicine units for twelve total sessions (4 each in Jan, Mar, May). Each session:

- 45-minutes with up to three scenarios
- Scheduled during protected resident educational time
- Provided real-time feedback

Anonymous post-mock code evaluations (Microsoft Forms) were completed after each session. Responses were reviewed periodically, and the script and scenarios were refined based on responses and observations.

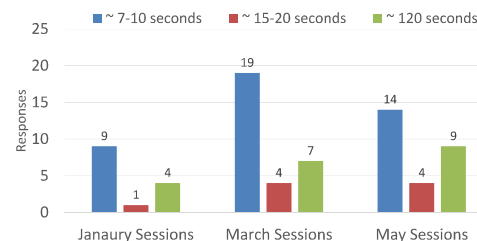
Results

Out of approximately 120 participants, 71 learners (43 nurses, 24 residents, and 4 support staff) returned surveys.

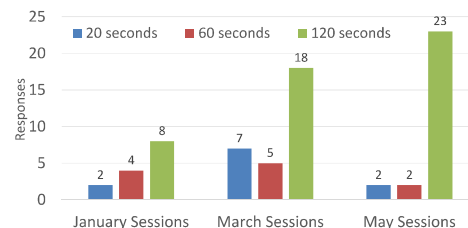
Knowledge Based Outcomes:

• AED Analysis Timing:

42 of 71 (59%) participants correctly identified 7–10 seconds as the minimum amount of time the defibrillator must be kept in AED mode to analyze the rhythm.



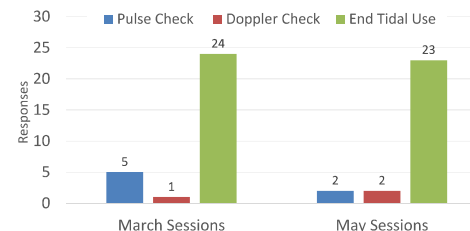
• Time to First Shock:



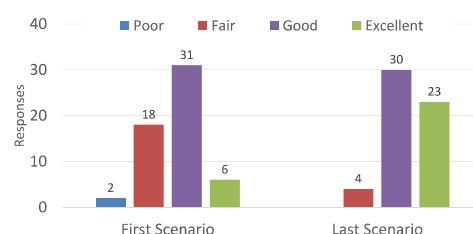
49 of 71 (69%) of participants correctly identified 120 seconds as time to first shock.

• End-Tidal CO₂ Use:

47 of 57 (82%) participants correctly identified its role in return of spontaneous circulation detection.



• Communication Rating (across all 12 sessions):



Overall improvements in "Good" or "Excellent" ratings from 37/57 (65%) in the first scenario to 53/57 (93%) in the last scenario in each session.

Results (continued)

Qualitative feedback from the participants:

Positive comments on:

- Enjoyed learning opportunities & coaching from the facilitators (17 participants)
- Improved communication (15)
- Increased CPR guidelines and AED knowledge (11)
- Improved teamwork/collaboration (8)

Negative comments:

- Timing of sessions during the day (1)
- Number of sessions (1)

Challenges

- Initial poor post survey participation after the first session but improved in sessions 2 and 3 after increased prompting
- Unable to include every resident or nurse due to schedules
- Difficult to simulate real environment due to
 - Lack of patient room availability
 - Nursing report rooms were utilized for ten sessions

Implications for Practice

During mock sessions, improvements were seen in communication, team coordination, knowledge of AED and end-tidal CO₂ use. Mock trainings were well-received by learners and facilitators. Continued interdisciplinary training with trained facilitators may continue to improve communication and CPR metrics.

Acknowledgements

Marida Twilley, RN, Lynne Farrow, RN: developed the script used as the foundation for the joint mock code script and supported facilitator training.



Transforming Patient Safety: A Nurse-Led Rapid Response Model

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Executive Champion: Karen Wyche, DNP, RN, NEA-BC, CENP, FAONL

MedStar Southern Maryland Hospital Center

ABSTRACT

At a 190-bed acute care hospital, delays in recognizing and responding to patient deterioration contributed to preventable adverse events. A 12-month review identified systemic barriers, including inconsistent escalation, communication gaps, and a dual-role ICU charge nurse serving as the Rapid Response (RR) nurse. A nurse-led Rapid Response Team (RRT) model was implemented using the Model for Improvement and PDSA cycles, incorporating dedicated staffing, standardized protocols, and proactive rounding.

Within six months, code blue events outside the ICU decreased by 30%, while RRT activations increased by over 70%. Mortality improved, with the Sepsis Mortality Index decreasing to 0.72 and the All-Cause Mortality Index to 0.50.

This initiative demonstrates that a proactive, nurse-led RRT model improves early recognition, strengthens escalation, and reduces preventable harm through a sustainable, equitable system of care.

INTRODUCTION/BACKGROUND

Early recognition of clinical deterioration is essential to preventing adverse patient outcomes. At our organization, variability in escalation practices and delayed response times contributed to increased risk of harm.

Problem Statement:

How can we improve early recognition and timely response to patient deterioration to reduce preventable harm?

Purpose:

To implement a nurse-led, proactive Rapid Response Team model that standardizes escalation, improves response time, and ensures equitable access to expert care.

METHODS

This quality improvement initiative utilized the Institute for Healthcare Improvement Model for Improvement and iterative Plan-Do-Study-Act cycles. The project targeted adult patients on intermediate care and medical-surgical units at risk for clinical deterioration.

A dedicated nurse-led Rapid Response Team (RRT) was implemented, supported by 4.5 full-time equivalents, eliminating the prior dual-role of the ICU charge nurse. The intervention included standardized escalation protocols, structured communication tools, and proactive rounding to identify at-risk patients and promote early intervention.

Data collected included code blue events outside the ICU, RRT activations, unplanned transfers, and mortality indices (sepsis and all-cause). Outcomes were evaluated through pre- and post-implementation comparisons over a six-month period.

RESULTS

Within six months of implementation, code blue events outside the ICU decreased by 30%, while RRT activation increased by over 70%, reflecting improved early recognition, escalation, and proactive intervention. Mortality outcomes also improved significantly, with the Sepsis Mortality Index decreasing to 0.72 from a median of 1.17, and the All-Cause Mortality Index decreasing to 0.50 (FY26 YTD 0.46 vs. 0.76 prior year). These outcomes indicate more timely interventions, reduced progression to critical events, and improved overall patient outcomes. Additionally, the initiative was associated with increased staff confidence in escalation, strengthened interdisciplinary collaboration, and more consistent access to expert-level care across inpatient units.

MSMHC Inpatient Code Blue and Rapid Response Calls

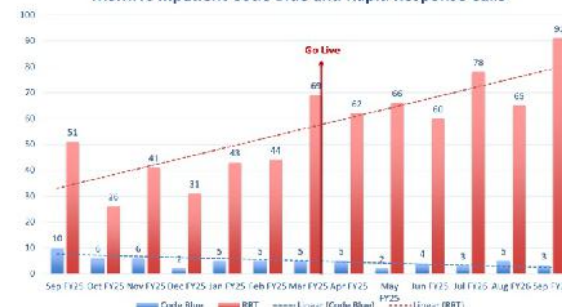


Figure 1—MSMHC Inpatient Code Blue & RR Pre/Post Implementation

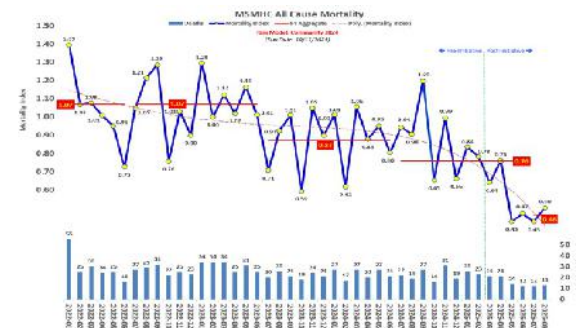


Figure 2—MSMHC All Cause Mortality Pre/Post Implementation

CONCLUSION

A nurse-led RRT model provides a replicable framework for healthcare organizations seeking to reduce preventable harm and strengthen patient safety through nurse-driven, system-level innovation.

Access Redesign for Safe and Equitable Patient Experience

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Abstract

Patient satisfaction and patient safety are fundamentally intertwined, as effective communication, streamlined processes, and equitable access all help prevent missed care, miscommunication, and potential harm. Research reinforces that when workflows are efficient and communication is patient-centered, organizations see measurable improvements in safety, satisfaction, and trust. Guided by these principles, the outpatient physical therapy clinic launched the Access Redesign for Safe and Equitable Patient Experience initiative to address low Press Ganey Access Scores and reduce barriers that disproportionately affected first-time visitors and non-English-speaking patients.

The initiative focused on simplifying the registration process, improving clarity in communication, and ensuring a more equitable front-end experience for all patients. Within just five months, the team achieved significant gains: Ease of Registration improved from 60.8% to 86.9%, while Access Overall increased from 57.8% to 87.0%, surpassing national World Class benchmarks. These improvements demonstrate how a low-cost, system-level redesign can strengthen safety and enhance consistency in daily operations. Ultimately, the changes created a calmer, more predictable, and more supportive environment—ensuring that every patient's first interaction with the clinic establishes confidence and trust.

Introduction/Background

Before this initiative, patient feedback and team observations revealed that front desk congestion caused check-in delays, inconsistent communication, and frustration—especially for first-time patients and those needing language assistance. Patients reported long waits and confusion about the next steps, which undermined their confidence in the care process. Because registration sets up the tone for the entire encounter, the team recognized that improving this process was essential to advancing patient safety, access equity, and experience. Research shows that registration delays and poor access disproportionately affect vulnerable populations, increasing risks of delayed therapy, and missed appointments (Rosenbaum et al., 2016; Betancourt et al., 2014).

Root Cause Understanding and Innovation

A multidisciplinary team—including front desk members, therapists, IT, and leadership—analyzed workflows and identified key contributing factors:

- ▶ A single front desk handled multiple competing tasks (check-in, scheduling, payments, inquiries).
- ▶ Communication and scripting lack standardization.
- ▶ Peak-hour capacity limits led to overcrowding and frustration.

The team redesigned the system by creating a dedicated check-out-desk staffed by a full-time technician who:

- ▶ Scheduled follow-up appointments.
- ▶ Answered patient questions.
- ▶ Used standardized scripts to ensure clarity and consistency.

This redesign relieved pressure at the main desk, improved patient flow, and enhanced engagement. Patients and family members provided feedback through post-visit surveys and rounding, which shaped scripting language and layout changes.

Methods

- 1. Workflow Mapping and Observation:** Team members and leadership documented patient movement to identify bottlenecks and communication gaps.
- 2. Process Redesign:** The team established a new check-out station, supported by IT and facilities to optimize layout and scheduling systems.
- 3. Staffing Adjustment:** Leadership created a full-time therapy technician position to manage check-out duties.
- 4. Scripting and Training:** Team members developed and practiced standardized scripts focused on empathy, clarity, and inclusiveness.
- 5. Team Engagement:** The redesign fosters a culture of proactive problem-solving and teamwork. This collaborative approach reflects best practices in system-level safety design and continuous quality improvement (Pronovost et al., 2006; Institute of Medicine, 2013).

Discussion

The initiative led to substantial improvements in patient access and experience, with Ease of Registration rising from 60.8% to 86.9% and Access Overall increasing from 57.8% to 87.0% within five months. These outcomes demonstrate that a low-cost, system-level redesign can meaningfully reduce registration delays, miscommunication, and patient frustration, especially among first-time and non-English-speaking patients who previously faced disproportionate barriers.

The findings align with literature showing that streamlined workflows and patient-centered communication improve safety, access, and trust in care interactions (Pronovost et al., 2006; Institute of Medicine, 2013). They also support national recommendations emphasizing standardized processes, team-based redesign, and equitable access as essential components of safer outpatient care. Limitations include implementation within a single clinic and reliance on Press Ganey metrics, which may not capture all access-related improvements. Future work could explore broader operational data (e.g., wait times, interpreter utilization), replicate the model across additional clinics, and evaluate long-term sustainability as staffing and patient needs evolve.

Conclusion

This implementation demonstrated that a low-cost, system-level redesign can meaningfully improve patient access, safety, and experience. Key outcomes included significant gains in Ease of Registration and Access Overall, along with stronger communication, reduced congestion, and improved understanding among first-time and non-English-speaking patients. These results highlight how small, targeted workflow changes can create more reliable and equitable care environments.

The findings contribute to the broader field by reinforcing evidence that standardized communication, task redistribution, and front-end process redesign directly enhance patient safety and satisfaction. This work also adds practical insight into how outpatient settings can address access barriers without adding staff, aligning with national patient-safety and health-equity priorities.

Based on the results, clinics should consider implementing dedicated check-out roles, standardized scripting, and workflow mapping to optimize patient flow. Continuous monitoring of access metrics and cross-training staff can help sustain these improvements and support broader replication across ambulatory sites.

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Results

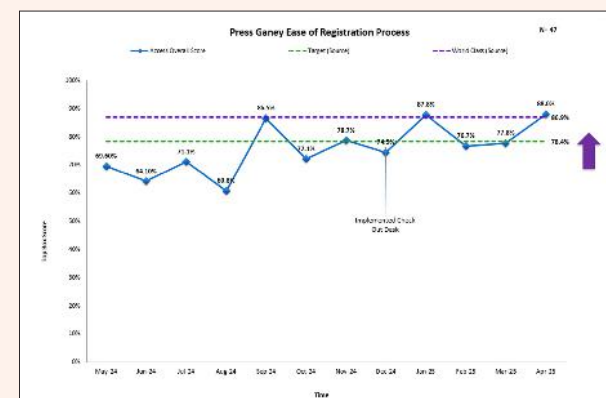
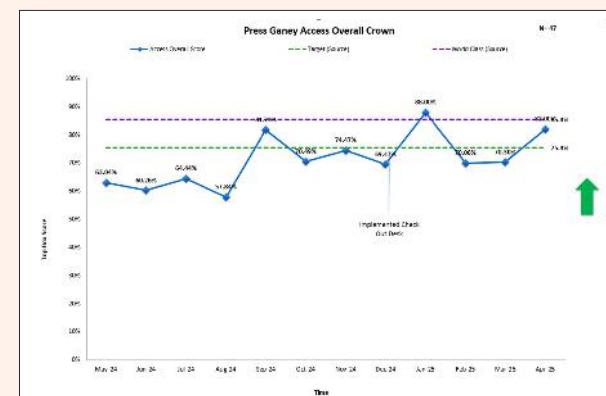
Qualitative Impact

- ▶ **Equity:** First-time and non-English-speaking patients reported greater understanding and confidence due to standardized scripting and interpreter coordination.
- ▶ **Safety:** Reliable follow-up and closure processes reduce risks of delayed care and missed appointments.
- ▶ **Culture:** Team members described stronger teamwork and shared accountability for patient experience.
- ▶ **Patient Feedback:** Patients shared that they felt “welcomed,” “less rushed,” and “better informed about next steps.”

These improvements demonstrate measurable gains in patient safety, access, and workforce satisfaction through simple, sustainable design.

Quantitative Results (5-month period)

Metric	Aug 2024	Jan 2025
Ease of Registration	60.8%	86.9%
Access Overall	57.8%	87.0%



SAFETY COACH PROGRAM: Improving a Culture of Safety Through Peer Coaching



EXECUTIVE SUMMARY

For over a decade, the *Safety Coach Program* at our facility has been a cornerstone of our organization's commitment to safety. In the past year, the program has been reinvigorated and reinvented in a way that better promotes safe, high-quality, and equitable care. The actions taken at our facility over the past year have led to a measurable and palpable cultural shift within the organization, encouraging real-time coaching opportunities and dialogue related to safe practices. This culture empowers staff to speak up and in turn drives teams toward continued process improvement and quality outcomes, resulting in safe and equitable delivery of care for all patients.

Multiple Takeaways

There are multiple takeaways from the work that has been done over this past year.

Increase of organization-wide data transparency. Feedback from both the coaches and the Q4 2024 *Safety Culture Survey* identified the need to better ensure that data, outcomes, and progress be shared across all levels from our Executive Team to frontline staff. This has been accomplished through the *Safety Coach Program* resulting in more frequent, open conversations around organizational safety.

More equitable delivery of care tied into the promotion of consistent, safe practices. Coaches are promoting a culture where each patient receives the same high-quality care for every encounter, no matter their location within the organization. Coaches are completing observations related to safe practices beyond those listed in their observation tools, which is a sign of a cultural shift that lends itself to an environment of safe, equitable healthcare.

Project Overview and Safety Challenge

Over the course of this 12-month period and in alignment with strategic goals, the program chair and executive champion conducted an inventory of current practices to better support and align with our culture of safety. The outlined initiatives aimed to address the challenges and barriers associated with a negative safety culture such as decreased staff engagement, low levels of employee trust in leadership, and subsequently, poor patient outcomes.

Safety Coaches at our facility take on the role of unit champion for safe practices, completing monthly required observations and submitting recognitions of staff who complete safe practices in their daily workflows. Program membership includes individuals from both clinical and non-clinical teams and is comprised of both frontline staff and individuals in leadership roles.

Membership is on a volunteer basis and staff are encouraged to utilize the program for meeting continuing education and clinical ladder requirements. Meetings are held monthly and include an overview of observation data, review of all entered *Good Catches/Near Misses*, and the selection of a monthly *Good Catch* winner. On a Quarterly basis, a coach is recognized, and a *Quarterly Safety Star* is selected and publicly celebrated.

Root Cause Understanding and Innovation

Through feedback from coaches and staff members, a lack of understanding of organizational goals related to safety and the impact and role of the Safety Coach was recognized. Additionally, *Safety Culture Survey* results showed staff were hesitant to speak up and felt a lack of support from leadership regarding safety. This feedback was utilized to reinvigorate the program to align with best practices with a focus on education surrounding safety culture concepts. The program historically was not inclusive of all patient care areas and lacked non-clinical representation. There was also a negative connotation associated with Safety Coaches, with staff believing Coaches were "secret shoppers," and contributed to disciplinary action. **Addressing these cultural barriers was identified as a key driver to the success of the program and overall increase of participation by staff.**

Implementation Approach

In alignment with our organizational strategic plan, goals were developed to increase participation in the program and employee engagement, subsequently decreasing patient harm events. Measurable program goals included increasing employee participation, engagement, meeting attendance, and overall number of observations completed by 25%. A plan was developed in coordination with the executive champion to include implementation methods to meet the outcome goals of the program. Key elements to this were the revision of the meeting structure and the addition of focused education and training of new and existing Safety Coaches.

The program partnered with an outside entity to provide training materials and certification opportunities to all coaches. This material was embedded in an in-person training session that was then transitioned into module-based learning to effectively on-board new coaches year-round. *All coaches, new and existing, can now become Certified Patient Safety Coaches through completion of additional learning materials and passage of the certification exam.*

The existing Observation and Recognition Tools were revised to be more succinct and to encourage observation in all areas, not limited to clinical staff. Example observation topics include Infection Control (Hand Hygiene, Personal Protective Equipment, and Equipment Decontamination), Communication (AIDET, SBAR, Whiteboard Updating), and Proper Patient Identification (Use of two identifiers, Protection of PHI). Additionally, a new section was added to be more conducive to the specific needs of the surgical environment including proper surgical attire, time out compliance, and use of sterile technique. These tools are used to record the Coach's monthly required observations and any real-time coaching that was completed.

Coaches are encouraged to recognize adherence to policy and process as a positive coaching moment as well as coach to opportunities for improvement when observed. This information was also included in the campaign for the program that was launched in October 2024 and was an important talking point in describing the program to hospital staff. A focus was placed on the method of data collection and portraying an overview of the type of data entered into the tool to decrease the negative connotation around these coaching moments.

The second item that coaches utilize is the **recognition tool**. Coaches use this tool to nominate those who consistently go above and beyond for promoting safe practices.

The recognized individuals are then entered to win a gift card at the monthly meeting. This was formerly completed utilizing a paper card that was then pulled for a drawing but has since been transferred to an electronic/QR code methodology for submission. This, along with the monthly and quarterly *Good Catch* recognitions, both aim to improve the overall perception of the program with a focus on celebrating the work staff do every day to keep both their patients and their peers safe.

Impact and Outcomes

Over the past year, our facility Safety Coach program has experienced a more than 400% increase in total completed observations and coaching opportunities, achieving, and surpassing the original goal of 25%. This growth is supported by a 265% increase in the total number of coaches across inpatient, ancillary, and supporting areas. In coordination with key stakeholders, the program has provided monthly education to the Safety Coaches with topics including Regulatory Compliance, Infection Control, HIPAA/Confidentiality, Patient Experience, Safe Communication Tactics, and Organizational Safety & Performance Measurement. The program recognizes both clinical and non-clinical areas on a monthly and quarterly basis for *Good Catch Awards*, *Safety Star Awards*, and *Sparkling Hands Awards*, which is a hand hygiene unit-based recognition. Additionally, the organizational Hand Hygiene Committee has now been merged into a joint reporting structure with the Safety Program, strengthening and exceeding organizational hand hygiene submission goals for the *Leapfrog Hospital Survey*.

Other indicators of success include an increase in overall safety event reporting, specifically in historically underreported areas, with a notable 24% increase in the total number of *Good Catch/Near Miss* entries. Our facility has also accomplished a 37.5% decrease in the volume of sentinel events reported year to date. These indicators represent a positive shift in the overall safety culture.



Over the past year, our facility Safety Coach program has experienced a more than 400% increase in total completed observations and coaching opportunities, achieving, and surpassing the original goal of 25%.

Sustainability, Spread, and Replicability

Future goals of our Safety Coach program include expansion across the health system, continued recruitment of new coaches, and an increase in the number of certified coaches within the organization. The Safety Coaches will also play a role in the organizational rollout of the *Peer Support Program* in the coming months. The Safety Coach program can be adapted at organizations of any capacity. Having a core implementation team that includes executive sponsorship dedicated to the team's success is key to overall achievement and sustainment of a successful program.

Other items to consider for replication include a program charter inclusive of measurable goals, role definition of members, and a comprehensive training program. The program should also be aligned with organizational strategic planning to include any current regulatory or statewide focuses on patient safety. Continuous improvements and adjustments are necessary and can assist in ensuring goals and standards are accomplished.

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Shorter Stays, Stronger Care: Reducing Pediatric Endocrine Length of Stay through QI

Samantha McQueen MSN, RN, LSSGB

Quality Improvement Department, UMMC



BACKGROUND & SIGNIFICANCE

As part of UMMC's endeavor to become a **High Reliability Organization (HRO)**, the Quality department tracks metrics, such as length of stay, that will aid in achieving this goal. Within Vizient's FY25 Efficiency domain, Pediatric Endocrine Length of Stay (LOS) was identified as a top priority and opportunity for improvement. The HRO principle most relevant to this work is **Sensitivity to Operations**, which emphasizes engaging frontline staff to understand current processes and identify opportunities for improvement (Gill, Leiner, & Steinberg, 2025).

This project aims to:

1. Enhance quality of care and patient safety through more efficient Endocrine admissions, specifically new onset diabetes.
2. Improve patient and family satisfaction and streamline workflows.
3. Reduce LOS variability to drive efficiency and decrease organizational costs.

PURPOSE

UMMC's Vizient Pediatric Quality & Accountability calculator ranking within the Efficiency domain, which is where LOS is housed, was 78th (20th percentile) for FY24. The metric itself is measured through an observed-to-expected ratio and resulted as **1.26** for FY24. The goal is to be at a O/E ratio of 1.00 or less. Having a longer observed length of stay to expected has negative impacts on patient experience and leads to higher costs to the hospital (Alharbi et al., 2023).

STRATEGY

After compiling baseline data to make a business case for this initiative, key stakeholders were determined such as Quality Physicians, Quality Improvement Leaders, Endocrinologist, Diabetes educator, Pharmacists, Residents, APPs, RNs, Nurse Leaders, Clinical Informaticists, and more. QI tools such as Gemba walks, Process Mapping, and Gap Analyses were conducted with said key stakeholders. Multiple opportunities were identified and acted on within separate subgroups through in-person and virtual meetings.

IMPLEMENTATION

Information Technology

- Made modifications to insulin sliding scale order set
- Integrated insulin dosing sheet into in-patient context for ease of access and editing for ordering providers
- Creation of Pediatric Diabetic Educator consult order and associated TigerConnect role

Point of Care

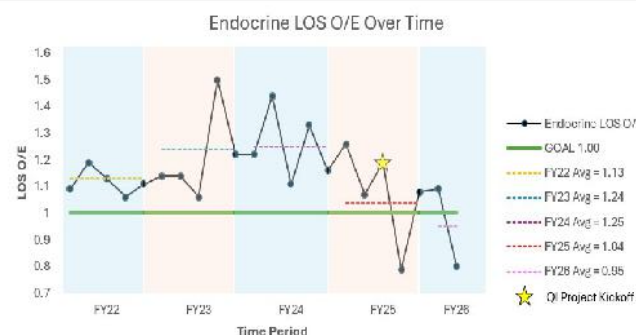
- Implemented POC HgA1c machine in Pediatric ED to expedite results for fully-informed care directives

Video Education

- Video integration into MyChart to ease accessibility for nurses, patients, and families allowing education to occur in any care area, including outpatient and home

EVALUATION & OUTCOMES

Data was tracked through Vizient's Q&A quarterly release through an Observed-to-Expected Ratio.



Endocrine LOS O/E improved from **1.26** in FY24 to **1.04** in FY25 after the implementation of this project. Through Q2 of FY26, it's averaging an O/E of **0.95**.

Vizient Quality & Accountability Rankings

2024 Annual (Recalculated) vs 2025 Annual

	2024 - Annual	2025 - Annual	
Overall	#27 (72%)	#17 (83%)	↑
Mortality (31.2%)	#12 (88%)	#7 (93%)	↑
Safety (31.2%)	#59 (40%)	#21 (79%)	↑
Effectiveness (25.1%)	#38 (61%)	#79 (19%)	↓
Efficiency (12.5%)	#78 (20%)	#26 (73%)	↑

IMPLICATIONS FOR PRACTICE

A key focus of this project was embedding process improvements directly into existing workflows, reducing reliance on education and memory-dependent behavior changes. By integrating identified opportunities into the routine care process, frontline staff can now deliver improved care through streamlined, built-in practices rather than added steps or reminders. Throughout this process, multiple unexpected barriers arose. It became clear that flexibility was critical in adapting interventions. Additionally, interdisciplinary approach strengthens solutions – deference to expertise catches blind spots. Decreasing length of stay for the Pediatric endocrine population not only lowers direct care costs but also improves overall operational efficiency such as bed availability and resource utilization.

NEXT STEPS

1. **Sustainment:** Monitor Endocrine LOS O/E metrics quarterly and maintain improvement through embedded workflow changes.
2. **Workflow Development:** Finalize and implement a standardized process for use of new HgbA1c machine in Pediatric ED.
3. **Education & Communication:** Roll out education sessions and share results across the Pediatric Division to promote situational awareness and continued engagement.

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TRACKing What Matters: Closing the Loop on Complex Problems

Meghan Schott, MSN, RN, Jennifer Arrington MSN, RN, CPHQ, Megan Weaver, BS



UNIVERSITY of MARYLAND
MEDICAL CENTER

PROBLEM

SOLUTION

IMPACT

BACKGROUND & INTRODUCTION



Frontline staff routinely identify operational and clinical challenges, but follow-up is inconsistent due to unclear ownership, communication gaps and siloed problem-solving.

Project Aim:

Implement a standardized loop-closure process to improve how complex, multidisciplinary problems are identified, prioritized, and resolved.

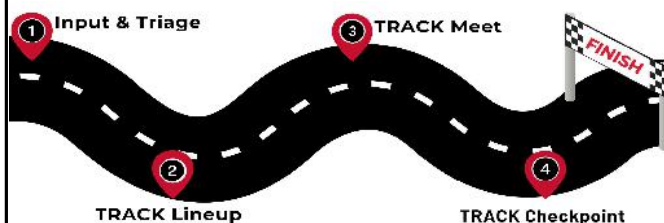
Identified Gaps



DMAIC Process Overview:

- A multidisciplinary team of leaders defined the scope, reviewed current processes and mapped workflows.
- Multiple reporting channels provided robust data (safety events, huddle reports, call-center logs) to identify problems and set improvement metrics.
- These insights shaped TRACK, ensuring a structured and transparent approach to issue resolution and loop closure.
- Each issue that is submitted is data tagged based on hospital priority area.
- Electronic tracking monitors progress and supports long-term sustainability.

METHODS & PROCESS



01 Input & Triage

Issues are submitted through an electronic platform and triaged. Scope is determined, and an evidenced-based impact matrix tool is used to prioritize submissions.

02 Track Lineup

Core Disciplines meet weekly to review issues. Responsible and accountable parties are assigned, and follow-up timelines are established. A definition of done tier is chosen preliminarily.

03 Track Meet

Key stakeholders collaborate to develop comprehensive solutions—not just temporary fixes. Standard questions guide the discussion, and a timeline for resolution reporting is set.

04 Track Checkpoint

Monthly reviews ensure progress on open cases and reassess low-complexity or out-of-scope issues to confirm no further action is needed. This step supports oversight and control.

BEFORE	AFTER TRACK
Unclear Ownership	Defined Accountability
Siloed Problem-Solving	Cross Disciplinary Collaboration
Inconsistent Follow-Up	Structured Checkpoints

OUTCOMES & EVALUATION

The TRACK pilot launched in Spring 2025 before bi-campus launch in Fall 2025. Since launching TRACK, issue visibility has increased, strengthening collaboration with Safety Huddles, Leader Rounding, and Patient Safety (RCAs). This has improved information capture, follow-up, and closed-loop communication, enabling more coordinated, system-level problem solving.

100+
Items
Submitted

77%
Issues Deemed
In Scope

95%
High to Medium
Complexity

29%
Full
Resolution

- Operations account for **38%** of issues.
- 8 issues linked to active TRACK work
- 4 issues referred outside of TRACK.

Key Takeaways



TRACK provides a scalable framework that strengthens communication, accountability, and coordinated problem resolution across teams, aligning with core HRO principles by promoting preoccupation with failure, sensitivity to operations, deference to expertise, commitment to resilience, and a culture of learning.

Please Scan QR code for
References, Acknowledgements &
Additional Information.



How the Use of AI Improved Quality Outcomes

ABSTRACT

In March of 2024, our hospital partnered with Palantir, a commercially available software provider for AI and big data analytics, that builds software platforms to augment data-driven operations and decision making, with a goal to improve patient throughput and quality of care. Initial areas of focus were reducing length of stay (LOS) in the observation setting, admission management to observation, and reduction of inpatient length of stay. The team demonstrated strong engagement with the tool, resulting in measurable length-of-stay improvements, and has shown initiative in expanding its use to monitor critical quality-of-care indicators. This tool has been fully hardwired into everyday standard work and assists in daily quality monitoring, throughput, and bed capacity operations. The team has seen improvement in patient safety and quality and advancements with patient flow and throughput. Leveraging the AI tool to assist with audit automation and real time detection of safety risks has improved patient safety by allowing a more consistent, faster, accurate means of surveillance and reduces staff burden allowing them more time for education, system improvement, and patient care.

PROBLEM

The team struggled with consistently completing daily audits while also balancing other daily patient care tasks. To relieve administrative burden and use resources most efficiently, we needed to produce innovative ways to complete necessary quality and compliance monitoring. Historically, when audits were completed, they were time-consuming and relied on manual sampling, requiring significant time and resources to compile, analyze, and act upon. The team sought a solution to support robust safety monitoring and ensuring timely access to data needed for constructive feedback, patient safety, and data-driven improvement.

Unit leaders and charge nurses collaborated to identify key priorities, including monitoring medication history compliance, conducting infection prevention audits, ensuring completion of admission documentation, and promoting patient mobility. By leveraging technology, leaders now receive real-time alerts when tasks are incomplete, enabling timely intervention and helping prevent patient harm.

AUDIT

REGULATIONS
LAW
US
ANALYSIS
PROCESS

Accurate & Consistent

Resource Management

Repetitive audit tasks such as chart review and compliance scoring can be labor intensive and take away from process improvement and patient care

Accuracy & Consistency

Manual audits can miss data and be inconsistent among reviewers

Visible & Broader Data Coverage

The need for faster data for quicker corrective action and safer patient outcomes

METHODS & WHY IT MATTERS

1.The deterioration tool provides **immediate alerts** when patients may require rapid response or intervention. This enables staff to act proactively—preventing harm before it occurs—rather than identifying safety concerns retrospectively. Additionally, resource nurses are alerted to support nurse residents and new-to- specialty team members.

2.Improved accuracy and consistency- manual audits can miss data or be inconsistent across reviewers. **Automation** uses standardized rules and algorithms ensuring objective and reproducible measurements of compliance and safety. For example, using the **quality tracker** the frontline nurses can monitor which patients received necessary **preventative care for central lines and foley catheters**, reducing the risk of a hospital acquired infections.

3.Visible automated dashboards and alerts allow teams to monitor compliance in real time—daily or even hourly—rather than waiting for lagging reports. **Faster data** translates into quicker corrective actions and safer patient outcomes. For instance, **mobility alerts** are sent directly to charge RNs when a patient has not been mobilized within 12 hours, prompting timely intervention to prevent deconditioning and other complications associated with immobility.

4.Broader data coverage- using the AI tool allows for 100% continuous review of patient records rather than small manual samples. This more **comprehensive approach** allows for systemic risk identification rather than isolated issues. This allows the team to see over time if there are **compliance issues with safety processes** such as medication reconciliation/history processes.

Safe: Avoiding harm to patients from the care that is intended to help them

Effective: Providing accurate care while avoiding underuse and misuse, respectively

Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care

Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy

Equitable: Providing care that does not vary in quality because of personal characteristics

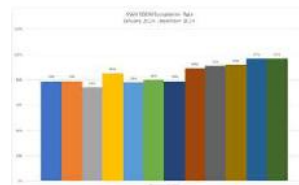
Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values

5. Reduces staff burden- automating repetitive audit tasks such as chart reviews and compliance scoring **frees up clinicians and quality staff to focus on education, system improvement, and patient care** – all of which directly impact safety.

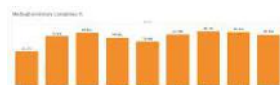
RESULTS

Using the Quality Tracker in Palantir, we have seen improvements in our Hospital Acquired infections, throughput measures, and regulatory compliance measures such as social determinants of health screening, and medication history compliance.

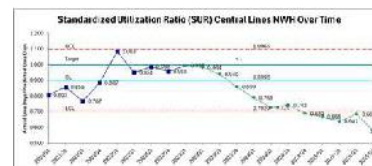
Improvement in screening for social determinants of health within the admission database. This process is vital for identifying patients' greatest needs related to housing or food insecurity, transportation barriers, utility challenges, and interpersonal safety concerns. Prior to implementing the Quality Tracker, completion rates averaged in the upper 70s to 80%. Following the introduction of automated alerts, screening completion increased to 97%, ensuring a more comprehensive understanding of each patient's circumstances and supporting more equitable, person-centered care.



Medication history is also tracked and is an important patient safety and quality metric. This allows us to appropriately address all patient medication needs and ensure safe management, thus preventing adverse drug events and improving continuity of care.



CAUTI and CLABSI monitoring using the Quality Tracker and alerting staff to potentially removable lines has decreased our utilization rates. Additionally, care alerts such as peri care and central line care have impacted overall infection rates.



July 2024 – December 2023

QSR S/R FY 2024 to date (July-Dec 2023)	CLABSI	CAUTI	C diff	MRSA
Actual Infections	3,664	2,506	11,529	2,112
Predicted Infections	0.006	0.394	0.178	0
QSR (Actual/Predicted)	6.668	6.5	0.351	0.65

TOOLS

Alerts

Alerts were used to identify patients who may be deviating from their plan of care. These tools track defined indicators such as mobility, early signs of deterioration, and infection prevention practices—allowing staff to intervene proactively in real-time and reinforce consistent use of best practices. The alerts also assisted in ensuring key foundational care coordination elements were performed, such as the admission and medication history for new patients. The use of these AI tools helped to shape hospital-wide behaviors to reduce potential harm events.

Example Message:
The following patients need nursing attention to stay compliant with NWH quality standards:
Need Peri-Care: 01-301, 01-0302, 01-0303
Need CHQ Treatment: 01-301, 01-0315, 01-0317
Need Admission Database completed: 01-302, 01-0312, 01-0314
Need Med History completed: 01-311, 01-0312, 01-0313

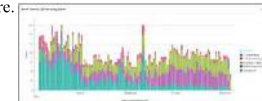
Dashboards/ Visual Management

- Interactive and displayed on the units, during rounds, and used throughout the day by the multidisciplinary team.
- Color coded to draw your attention to immediate actions needed.



Engagement Analytics

- The tool allows us to analyze how the team is interacting with the dashboard and thus the impact on behavior. The team can view when alerts are acknowledged and when action is taken, or if the alerts are left to expire.



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Their Safety. Their Voices. Our Promise.

Maulik Thaker

Anson Babu

Shelby Davis

Abstract



Objectives

- Zero Preventable Harm as the systemwide vision
- Safety embedded into daily care, workflows, and culture
- Large network: acute care hospitals + 150+ community locations
- Before SafeCare: fragmented reporting, limited transparency, slow follow-up
- 2022 launch of SafeCare as one cloud-based platform
- Unified Quality, Patient Safety, and Risk Management reporting
- Shift from reactive response to proactive prevention
- Standardized workflows and automated routing across facilities
- Real-time dashboards and demographic data for trend detection
- Shared worklists, notifications, and simpler review processes
- Reporting increased from ~500 to ~1,400 events per month
- 180% increase reflects stronger engagement and transparency
- Better visibility supported safety grades and state indicators
- Reduction in hospital-acquired conditions
- Stronger culture of learning, accountability, and everyday safety

Methods

A standardized, three-phase risk management framework was used to systematically assess, manage, and monitor risks across the organization.

1. Risk Assessment

Risks were identified through brainstorming, surveys, expert interviews, and review of industry data. Threats were categorized (e.g., operational, financial, regulatory, health & safety; internal vs. external). Each risk was evaluated based on likelihood and impact, using a risk matrix (1–10 scale) to prioritize severity and guide decision-making

2. Risk Management

Prioritized risks were addressed using four evidence-based strategies:

- Avoidance (eliminate high-risk activities)
- Acceptance (tolerate low-impact risks)
- Transfer (shift risk via insurance or partnerships)
- Mitigation (reduce likelihood and/or impact through controls)

3. Risk Monitoring

Risks were continuously monitored and reassessed to capture emerging threats and evolving conditions. A centralized Risk Management Information System (RMIS) was utilized to aggregate data, track trends, and support real-time decision-making and workflow efficiency.

Results



Discussion

•Utilizing the SafeCare platform as an all-in-one solution promoted transparency and collaboration among departments using standardized forms for added efficiency

•Standardized event reporting allowed for capturing a larger group of event types while also consolidating event type categories

•Change control governance allows for continuous optimization wherever appropriate, and these enhancements can be made independently by SafeCare System Admins

•Real-time data within the platform further promotes data transparency to allow leaders to prioritize added focus or resources to the areas and depts that need it most.

•Accessibility – There were several options made available to report a safety event and that coupled with marketing (QR Code, Screen save, link in Cerner, Intranet page with resources)

•Resources included process maps, how to guides and videos to power end-user. Additionally, the system had hardwired prompts to serve as guard rails for successfully completing steps in the system.

Conclusion

- , Culture of transparency and trust: A 180% increase in event reporting reflects improved safety and staff engagement
- Systemwide standardization: Consistent definitions, workflows, and routing improved accountability, reduced delays, and strengthened follow-up across all facilities.
- Human- centered design improves reliability: Simplified workflows, automation, and clear ownership reduced cognitive burden, increased efficiency, and achieves 96% review completion rates.
- Integrated system drives transformation: Implementing a simple, cloud-based based platform (SafeCare) eliminated fragmented reporting and created a central source of truth for patient safety, quality, and risk data.
- SafeCare is the name we call it at LifeBridge. It is a product of Riskconnect and is a cloud-based Salesforce application



Reducing Form Fatigue Through the Power of One: A Smarter Way to Report Events

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Abstract

Timely, accurate event reporting is essential for proactive risk detection and continuous safety improvement. Over time, our event reporting became overly complex, with 22 separate Event Entry Forms and inconsistent data entry patterns creating barriers and delaying submissions. To address this, we implemented a streamlined, user-centered redesign of the event entry workflow.

Early Results

- Faster submissions (downward trend in time)
- 73% reduction in incomplete events (now 1.5%)
- 69% reduction in file type corrections
- Improved accuracy in event classification

These improvements demonstrate how simplifying the reporting process can significantly enhance the overall user experience while strengthening data quality and reliability. By making it easier for team members to report events accurately and efficiently, the redesign supports more timely insights and enables faster, more informed patient safety decisions.

Key Background Points

- **Submission Time Variability:** Although average submission times met targets (14–16 minutes), 7 of 22 forms exceeded the 15 minute benchmark each month, signaling workflow inefficiencies.
- **Form Fragmentation:** Twenty two separate event forms — some requiring up to 35 fields — created unnecessary complexity and slowed documentation.
- **Workarounds Emerging:** Increased use of the faster Provider Quick Entry Form showed that staff were prioritizing speed over completeness, resulting in inconsistent data quality.
- **Behavioral Impact:** Team members faced to choosing between a slow, detailed process or a fast, incomplete one, reducing the likelihood of accurate, timely reporting.
- **Problem Reframing:** Instead of focusing on training, the project asked how to improve the reporting experience itself to strengthen data integrity and enhance patient safety

Methods

We used a user centered redesign approach to simplify the RL Datix event entry workflow and reduce reporting burden. The project involved a full review of all existing risk event forms, analysis of reporting patterns, and collaboration with leadership and stakeholders. Findings from this assessment informed the development of a single adaptive Quick Entry Form designed to streamline documentation while preserving essential data.

Key Steps in Methodology

- **Population & Data Sources:** Included all team members submitting patient safety events; data were gathered through a full audit of 22 RL risk forms, required fields, picklists, and event type utilization.
- **Stakeholder Engagement:** Conducted structured discussions with leadership, key stakeholders, and PSO team members to understand reporting behaviors, workflow challenges, and downstream review needs.
- **Form Audit & Analysis:** Reviewed each form to identify redundant fields, duplicate documentation, overlapping event types, and unnecessary complexity.
- **Event Type Consolidation:** Grouped similar events into broader classifications to simplify selection while maintaining regulatory compliance.
- **Field Reduction & Reorganization:** Removed nonessential fields, streamlined picklists, and reorganized sections to support natural documentation flow.
- **Design of the “Power of One” Form:** Built a single adaptive Quick Entry Form using conditional logic to reveal only relevant fields based on user selections (location, person affected, event type)

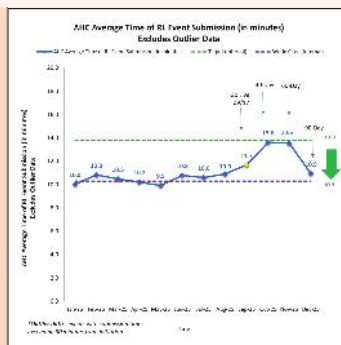
Results

We evaluated the impact of the redesigned RL Datix workflow using the following key measures: average submission time, incomplete event percentage, file type changes, and Provider Quick Entry conversions. Early data show meaningful improvements in reporting efficiency, data integrity, and workflow accuracy, with continued monitoring planned to assess long term trends.

Key Findings

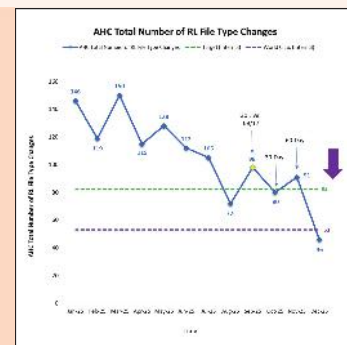
Average Submission Time (TAT):

- A temporary post-go live increase reflected normal learning curve adjustments.
- A spike at Day 90 prompted deeper review, revealing that incomplete events left open overnight were skewing results.
- After removing outliers (events submitted >30 minutes after start), the data show a clear downward shift, indicating improved efficiency.



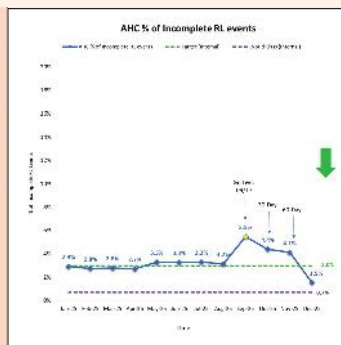
File Type Changes:

- Incorrect event type selection decreased significantly, reducing file manager workload.
- By December 2025, only **46 file type corrections** were made — a **69% reduction** from the March 2025 peak.



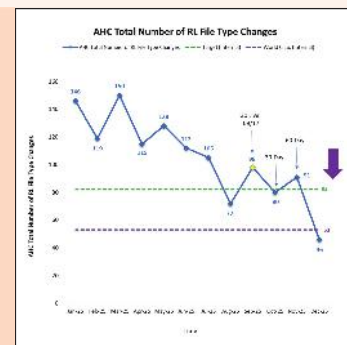
Incomplete Events:

- Incomplete submissions were monitored to identify workflow barriers and ensure the redesign did not create new points of failure.
- By December, incomplete events decreased to **1.5%**, representing a **73% reduction** from go live.



Provider Quick Entry Conversions:

- In March 2025, 51% of all file type changes originated from Provider Quick Entry submissions.
- By December, this dropped to **23%**, indicating improved accuracy and adherence to the new process.



Conclusion

Adventist HealthCare successfully implemented a user-centered redesign of the RL Datix event-entry workflow, reducing complexity, strengthening data quality, and improving the overall reporting experience. By consolidating forms, eliminating unnecessary fields, and introducing a single adaptive Quick Entry Form, we created a more intuitive and efficient process that supports accurate and timely event reporting.

Early outcomes demonstrate meaningful improvements across key measures:

- Reduced submission time
- Fewer incomplete events
- Improved file type accuracy
- Performance meeting or exceeding targets, approaching world-class levels

These findings reflect an initial three-month post-go-live snapshot and reinforce that simplifying the reporting experience positively influences both user behavior and data integrity.

While results are promising, ongoing monitoring and analysis will continue to evaluate the long-term impact of this redesign on organizational safety and reporting culture, ensuring sustained improvement over time.

Improving Staff and Patient Safety Through Redesign of Safe Patient Handling and Mobility Education

Melissa Zalesak, OTR/L, SCCE¹ and Sharon Khoo, M.S. CCC-SLP²

¹Occupational Therapist IV (Lead), ² Manager, Rehabilitation Services

RELEVANCE & SIGNIFICANCE

- Although evidence supports the benefits of early mobility for hospitalized patients, staff often struggle to select mobility techniques that are safe for both themselves and their patients.
- Kolb's Experiential Learning Theory shows that hands-on experience is the foundation of learning as it anchors understanding and skill application.
- Hands-on training** and competency in mobility techniques and safe patient handling (SPH) equipment are key to reducing lift injuries and related healthcare costs.

PROBLEM/GOALS

- An increase in the number of staff lift injuries was noted during FY25. Onboarding education in SPH was fragmented and primarily didactic.
- Our goals were to:
 - Improve onboarding education with increased **hands-on training**
 - Reduce the number of staff lift injuries
 - Improve rates of out of bed activity for patients

STRATEGY

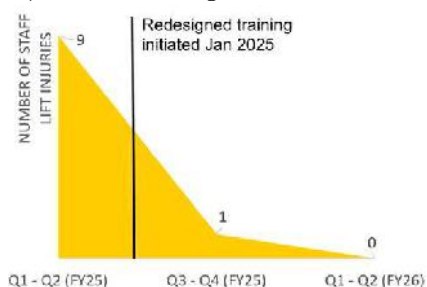
- Redesigned onboarding education became part of CRMC's Early Mobility Initiative.



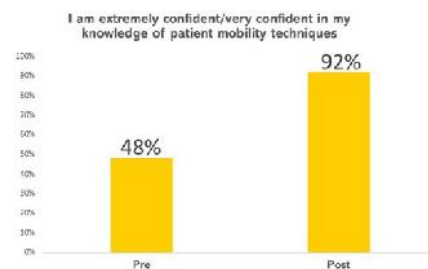
- Two separate modules taught by Rehab and Nursing were consolidated into one module with an expanded topic list and competencies.
- Hands-on training** was increased to 90 minutes.

EVALUATION & OUTCOMES

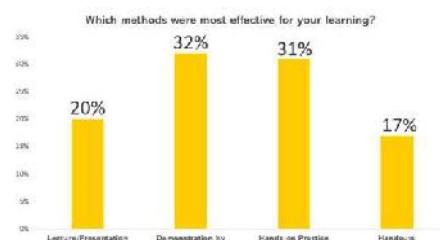
- Since implementation of the new training in January 2025, there has been a marked decrease in lift injuries to nursing staff.



- Survey data shows a positive impact on staff confidence.

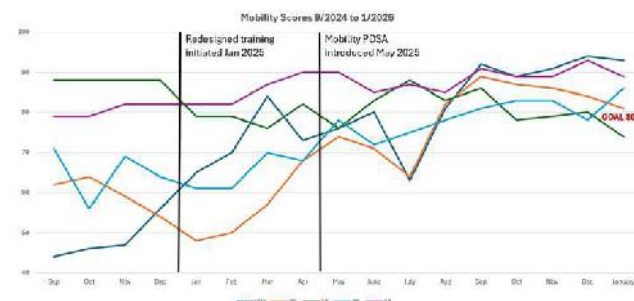


- Staff confirm that demonstration and **hands-on** practice are most effective for learning.



"The training was great! It was engaging, fun, and the hands on was very helpful."

- There was also an improvement in rates of out of bed activity for patients.



IMPLICATIONS FOR PRACTICE

- Standardized, **hands-on training** ensures:
 - Every patient receives consistent SPH and mobility techniques regardless of which staff member is working.
 - Patient safety practices become hardwired and contribute to a culture of zero harm.
 - Staff feel more confident which reduces anxiety and fear of injury. Increased confidence also leads to higher job satisfaction and retention.

NEXT STEPS

- Offer ongoing classes in the event of a lift injury and for staff skill refinement.
- Expand training to all staff who handle patients e.g., transporters, security.
- Train Mobility Champions on each nursing unit to provide just-in-time training and assistance.

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“Sharpening our Focus on Workplace Violence Prevention and Response”

Kirsten Edler, MSN, CRNP, CPPS, CPHQ; Christina Arnold, BA ;Holli Foltz, BSN, RN; Mark Goodwin, BA; Laura L. Jackson MBA, BSN, RN, NEA-BC, CPHQ;

Executive Summary: Promoting and maintaining a safe work environment is a top priority for our organization and a focus of our Patient Safety Program. Studies show that workplace violence poses a significant threat to the health, safety, and well-being of health care workers, which negatively impacts productivity, retention, and the overall quality of care provided to patients. That is why our organization is committed to ensuring a culture of safety so that every team member feels safe when they come to work.

Specific interventions were created and put in place to prevent workplace violence as well as manage the event after it occurred. These interventions addressed employee mental and physical well-being and have demonstrated a measurable decrease from Fiscal Year (FY) 2025 to FY 2026 to date in physical assault incidents. We created a built-in systems response for reported workplace violence to ensure equity for both our team members and the patients involved. With the development of our “Post-Event Leader Response” huddles and our “Department Debriefs,” any organization would be able to adapt these processes.

Implementation Approach: The approach we took to evolve our organization’s workplace violence program included multiple initiatives that addressed all elements of a high-quality culture of safety. Some of these initiatives include:

Designating workplace violence as a corporate goal by:

- Reducing the incident rate of physical workplace violence by 20% over 3 years (FY 25-27)
- Maintaining a culture that supports 100% incident reporting
- Designing a timely “Post-Event Leader Response” composed of a standardized multidisciplinary group which includes attendees from Senior Leadership, Accreditation and Regulatory Compliance, Employee Health, Security, Human Resources, Risk Management, Service Excellence and Unit Leadership, to implement next steps to manage the situation, the patient and support the impacted employee(s)
- Creating a “Department Debrief” for the purpose of providing a platform to listen to the staff impacted by difficult workplace violence situations that are challenging to manage, and then utilizing the feedback for proactive system-wide improvements utilizing a Single Case Bore tool to identify the patient population that results in the highest reports of physical assault in workplace violence leading us to a more focused generation of initiatives.
- Improving the accessibility and awareness of event reporting by updating graphics and marketing efforts and expanding our Patient Safety Hotline reporting options to capture workplace violence events

Project Overview and Safety Challenge: In response to the 2021 Culture of Safety (COS) survey results, we set out to create and implement a true and comprehensive Patient Safety Program that honored our mission “To positively impact the well-being of every individual in our community” and vision “To be a trusted choice for superb quality, service and value”. Our top opportunities for improvement indicated that staff did not feel empowered or free to report workplace safety events.

Our most recent Press Ganey survey in 2025 and our Agency for Healthcare Research and Quality (AHRQ) pulse survey indicated that we have shifted our culture and are seeing the change we desire. As we continue to mature our Program, it became clear that the reporting and reduction of workplace violence has been a top priority for our front-line team members and our entire organization. Being safe at work is a basic need required to facilitate compassionate care of our patients. As physical assault rises to the top of our patient safety initiatives, the organization continues to lend support by including the reporting of workplace violence and reduction of physical assault in its corporate goals which now includes Board oversight and support.

Root Cause Understanding and Innovation: An effective Patient Safety Program requires cultivation of a high-quality culture that begins with a transparent approach to reporting events and unsafe conditions without fear of punishment or retribution. With an increase in the number of workplace violence events reported, we have been able to identify root causes and contributing factors more effectively within our organization by designing a new and innovative approach in collaboration with our team members, ranging from front-line staff to senior leadership. This collaboration trickles down to impact our patient experience and provision of care.

As we continue to see measurable progress towards our goal, we have sharpened the focus on workplace violence prevention through the implementation of new initiatives while continuing to focus on the following:

- A shared belief that the high-risk delivery of healthcare can be designed to prevent failures and harm
- Inclusion of key stakeholders in assessment and decision making related to program foundation
- Organizational commitment to recognition and investigation of patient and employee injury and near misses
- Open and transparent communication and a “Just Culture” that balances the necessity to learn from our mistakes and to take corrective action when appropriate

All Physical Assault Workplace Violence Event Submissions FY2024 - FY2025



- FY25 Goal: 9.0
- FY25 YTD Average: 8.3

Impact and Outcomes: One of our corporate goals is to reduce the number of physical assault related workplace violence incidents by 20% over three years (FY 25-27). Our goal for FY 24-25 was to have less than, or equal to, an average of nine physical assault incidents. We met our target for FY 25 with an average of 8.3 incidents. Our current goal for FY 25-26 is to have less than, or equal to, eight physical assault incidents. Our second corporate goal focuses on maintaining a culture that supports 100% incident reporting. Since the beginning of Calendar Year 2025, we have seen a steady increase in the total number of workplace violence events reported.

We also developed and dispersed a survey about our “Post-Event Leader Response” initiative to the team members that had been impacted by workplace violence since the implementation of the initiative, as well as a survey to their Leaders, to help understand the impact of the initiative thus far. Nine team members and eleven leaders participated in the survey, and we had a 100% positive response rate indicating that participants felt supported by our “Post-Event Leader Response” huddles.

Additionally, as part of the huddles, the patient’s safety and wellbeing is also reviewed and validated 100% of the time.

Sustainability, Spread, and Replicability: Workplace violence in healthcare remains a significant concern in the United States. According to the U.S. Bureau of Labor and Statistics, healthcare workers are five times more likely to experience violence than workers in other industries. Workplace violence in healthcare can have a significant impact on workers, employers, and patients. It can lead to physical and psychological injuries, increased stress and anxiety, absenteeism and turnover, reduced productivity, burnout, and more. That is why it is crucial to address workplace violence to protect the safety and well-being of healthcare workers to ensure their focus is on eliminating preventable harm and advancing equity in patient care.

Our Accrediting body, The Joint Commission, and our Regulatory body, the Centers for Medicare & Medicaid Services, have also defined standards for hospitals to address workplace violence, which have continued to guide us as we build and refine our program. Since the implementation of our comprehensive Patient Safety Program in 2021, our efforts have been ongoing and include a daily overview of employee safety events. This has allowed us to integrate seamlessly with front-line team members affected by workplace violence, senior leadership, unit leadership and other key stakeholders, to ensure our prevention and response efforts continue to grow and improve over time.

Additional innovative elements of our workplace violence prevention and response efforts include:

Collaboration between our Security and Clinical Teams to revise and improve our “Code Green” policy regarding the proper handling of aggressive patients and/or visitors Re-educating staff on the components of our “Management of Disruptive Patients and/or Visitors” policy regarding how to manage patients and/or visitors who engage in disruptive behaviors that impact the functioning of the clinical unit and/or jeopardize the treatment or safety of patients, staff or other visitors

Reviewing our current “Approach With Care” program to identify new ways to enhance staff safety

Partnering with our Marketing and Communications Department to review and update our current public facing signage and information regarding workplace safety to ensure patients and visitors are aware that abusive or violent behavior is not accepted at our organization

We are proud of the level of transparency and open communication we have created regarding the topic of workplace violence in healthcare to proactively manage the issues within our own organization. The development and sustainability of a robust workplace violence prevention and response program can be easily replicated and/or adapted by other organizations by mirroring our vision and utilizing the initiatives we have designed to ensure a culture of safety so that every team member feels safe when they come to work.

Patient Safety: Three-Lens View “9 Grid”

	PATIENT	STAFF/COLEAGUE	ORGANIZATION
COMMUNICATION	- Roundback with Provider and Family on Phone - Bedside Shift Report	- Senior Leader Roundback - Incident Unit	“Close the Loop”
TEAMWORK	Medication PWEA: Diabetes	Behavior Concern Patient	- Patient Safety Corner Newsletter - Hand Hygiene
TRUST	Interpreting Services	Patient Safety Rounds	Workplace Violence Prevention

MISSION & VISION





Mission:
To positively impact the well-being of every individual in our community.

Vision:
To be the trusted choice for superb quality, service and value.

CALVERTHEALTH CARES: A Commitment to Violence-Free Workplaces

Background

Workplace violence (WPV) is defined by the Occupational Safety and Health Administration (OSHA) as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the worksite. It ranges from threats to verbal abuse, physical assaults, and homicide. It is a recognized hazard within the healthcare industry and can affect employees, staff, patients, and visitors.

The Maryland Hospital Association (MHA) has prioritized addressing workplace violence in 2025. In 2024 the CalvertHealth Associate Vice President of Ancillary Services and Director, Safety and Security joined an MHA workgroup to assist in the development of a dashboard for Maryland hospitals, aimed at improving the collection and analysis of workplace violence data. CalvertHealth was among the few hospitals in the state to contribute up-to-date data for this initiative.

The CalvertHealth Workplace Violence Committee continues to assist staff in identifying and mitigating unsafe situations. CalvertHealth encourages all its employees and staff to report any incidents of workplace violence committed against its employees, patients, or visitors in the hospital incident reporting database (SafetyNet). The reporting of workplace violence incidents assists CalvertHealth leadership and the WPV Committee in calculating incident and prevalence rates, identifying risk factors, and implementing prevention efforts. A new tool was developed for reporting which consisted of reporting, incident, follow-up, OSHA reporting, and providing employee assistance after the event.

Definition and Statistics

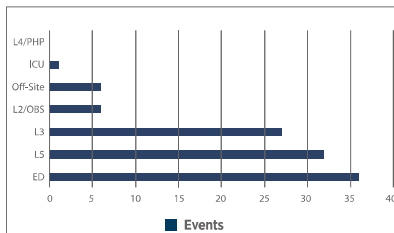
Occupational Safety and Health Administration (OSHA) defines **Workplace Violence** as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the worksite.

Unintentional Violence: is defined as violent and disruptive acts and behaviors committed by individuals who present to CalvertHealth with a condition (dementia, delirium, substance intoxication, or decompensated mental illness) or disability, which may result in workplace violence.

Intentional Violence: is defined as violent and disruptive acts and behaviors who DO NOT present to CH with a condition (dementia, delirium, substance intoxication, or decompensated mental illness) or disability, which may result in workplace violence.

In 2025, eighty-two of the reported one hundred-ten (74.5%) workplace violence events at CalvertHealth were classified as Intentional events and twenty-eight (25.4%) were classified as Un-Intentional. Of the total events, sixty-seven (60.9%) were physical violence and 19 (17%) were classified as verbal abuse.

2025 WPV EVENTS BY LOCATION



2025

32% of reported workplace violence incidents occurred within the CalvertHealth Emergency Department

29% of reported workplace violence incidents occurred within the In-patient Behavioral Health Unit

74.5% events- Intentional
60.9% physical violence
17% verbal abuse

25.4% events - Unintentional

CHS Workplace Violence (WPV) Committee

The CalvertHealth WPV Committee collects and analyzes data on WPV incidents and educates staff in recognizing precursor signals of violence. The committee is dedicated to decreasing caregiver injuries occurring from violence by patients, families, or visitors. The committee meets on a routine basis to develop and implement policies and procedures to provide a safe environment for all.

The total number of events rose dramatically from 2024 due in large part to the tendency in violent behaviors with some patients and the encouragement of staff to report WPV Events. The Emergency Department remained the highest percentage for WPV Events. Emergency Departments and Behavioral Health Units nationwide remain the highest areas for healthcare-related workplace violence incidents.

Acknowledgements:

Kara Harrer, PharmD,
AVP of Ancillary Services

Dan Lewis, Director of Safety
and Security



References

Processes Implemented 23-2025

- Multidisciplinary Team Formed in Jan. 2023
- Policies and Procedures defined
- A safe environment provided for employees, patients, and visitors
 - Security cameras and badge access
- Annual education and training for all CalvertHealth Staff
 - High risk areas recognized
 - Crisis intervention Training (CIT-MASADA)
- WPV reporting tool developed along with toolkit to develop action plans to address gaps
- Security vulnerability assessment performed in 2023
- Site inspections and interviews with staff
- Continue to review Workplace Violence incidents and determine contributing factors.
- Review recommendations for security vulnerability and implement action plans
- Provide and expand de-escalation, self-defense, and active shooter training to all CHS staff
- Evaluate security staffing in ED
- Continue to review Workplace Violence incidents and contributing factors
- Desk management system added for check-in

2025 Results/Outcomes

- 100 % of staff completed new de-escalation/ disengagement training videos in May 2025
- 41% (514/1250) of CalvertHealth staff completed 4-or 8-hour hands on training and increased classes to monthly
- Staff demonstrated 41% improvement in confidence and skills across all measured domains after hands on CIT-MASADA training
- Training security staff members to ascertain how a workplace violence event occurred and how to offer immediate guidance to the staff member to possibly mitigate an event in the future (*such as positioning or calling for security to stand by or assist prior to interaction with the individual.*) - 100% complete
- New signage in hospital, off sites and CalvertHealth Medical Group (CHMG) physician offices
- In 2025, 74.4% of staff felt that we had appropriate workplace aggression policies, procedures, and training in place from the Patient Safety Culture Survey at CalvertHealth which supports retention of staff and current turnover rate of 3.12%.
- Onsite Active Shooter drill completed in November of 2025
- Nursing residents completed a project on Workplace Violence in Healthcare settings at CalvertHealth

Conclusions

- Reinforcement of the purpose of the purple signage and light to the ED Department/Inpatient areas for staff self-awareness and safety
- Implement the "Buddy System" when entering violent patients' rooms for protection (purple signage)
- The buddy system is when an additional person accompanies the primary into the room.
- Education on signs of violent behaviors will increase staff preparedness & provide opportunity for interventions to be set.
- Creating a section in Meditech to "flag" patients at discharge who had violent behaviors during their visit, to flag the patients' chart on their next visit. This will assist in helping to reduce violent events before they occur.

Key Take Aways

At CalvertHealth Medical Center, our FY23-FY28 strategic plan includes a focus on Culture and Competence. Under this initiative we build organizational structure, standards, processes to implement strategy and ensure outstanding performance. By integrating a Workplace Violence Program at CalvertHealth, we have developed patient, visitor, and employee safety at our organization. This is an example of aligning our organizational culture with practical safety measures

Staff demonstrated an average 41% improvement in confidence and skill across all measured domains after hands on class CIT-Masada training. The most notable gains were in feeling of safety (+53%) and physical self-protection (+49%) after training. Training quality and engagement remain strong differentiators.

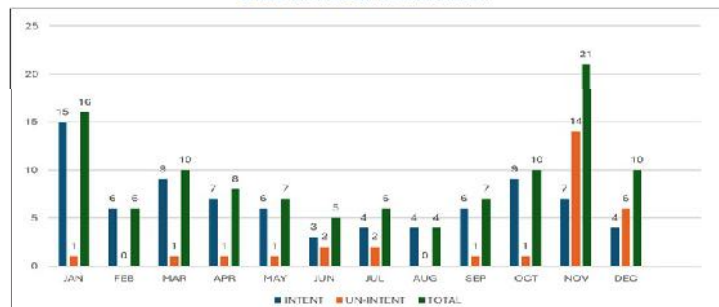


Goals for 2026

- ✓ Addition of Purple signage and purple light notification
- ✓ CalvertHealth Medical Group and Offsite Practices - Training March 2026
- ✓ Implementation of Evolve Weapon Detection Systems
- ✓ Medical Staff Training
- ✓ Representation on WPV Committee from CalvertHealth Medical Group
- ✓ Quarterly 15- minute staff de-escalation booster drills on units
- ✓ CIT-MASADA training within 3 months of hire
- ✓ Continue annual survey tracking for sustained improvement
- ✓ Enforce Wellness and Resilience Programs (EAP, Care Strong Team, and Peer Support)
- ✓ Add staff panic buttons and locators
- ✓ Additional Security cameras being installed



2025 WPV EVENTS BY MONTH



➤ **79 reported WPV Events in 2024**
110 reported WPV Events in 2025