Lisa Rowen’s Rounds: Interweaving Tragedy and Inspiration

Working in health care exposes us to a multitude of tragic and heartbreaking situations. Frequently, I am struck by the blended nature of these circumstances, which always reminds me that tragedy is often interwoven with acts of inspiration.

Consider Angela Weir, BSN, RN, CCRN, a senior clinical nurse in the Critical Care Resuscitation Unit, who came upon a horrific, fiery motor vehicle crash in the early morning hours on her way to work out. While not a first responder, Angela asked her husband to pull over so she could offer her help and expertise. In the darkness, Angela jumped over the Jersey wall without realizing she was on a bridge. Free-falling about 100 feet, Angela believed these moments in the air would be her final ones. Although jagged rocks were on either side of her, she landed in water and was able to swim to shore.

Calling for help, the first responders on the accident scene above her were able to pull Angela to safety and transport her to the UMMC R Adams Cowley Shock Trauma Center, where she was admitted as a patient to the Trauma Resuscitation Unit (where she used to work), and where her beloved colleagues cared for her with their extraordinary skill. Angela told me she would do the same thing all over again if necessary, albeit this time knowing where she was placing her feet. From the tragedy of a terrible crash, an inspirational act of kindness and response to human need arose. Thank you, Angela, for inspiring each one of us in how you modeled kindness as a human being and extending yourself as a skilled and caring nurse in a terribly dangerous situation.

Consider Kevin Ben, a mental health associate in the Child Psychiatry Day Hospital Program. Two decades ago, Kevin brought his 2-year-old son to UMMC to be treated for cancer. Kevin lived through this tragedy as a loving father praying for his son to return to health. Inspired by the excellent care his son received, Kevin decided he wanted to “give back,” so he joined the UMMC team as a volunteer. This experience led him to grow his career in health care and take care of fragile children to honor the care his son received, the caregivers who provided it, and other pediatric patients who need specialized care. By the way, Kevin’s son is now a healthy 23-year-old man. Thank you, Kevin, for not only caring enough to pay it forward through your volunteerism, thank you also for making health care at UMMC your profession.

Consider Tamesha Bell, a certified nursing assistant on the Pediatric Intensive Care Unit. She witnesses tragic situations daily and was so inspired by how her patients, their family members and her colleagues rise up to meet the challenges, she enrolled in the University of Maryland School of Nursing to continue her own professional development. In addition, Tamesha has quickly established herself as the PICU’s artist-in-residence by helping to brighten the environment for its young patients. (Read more about Tamesha’s contributions on page 13.) Thank you, Tamesha, for your motivation to continue your education, your desire to develop your skills and expertise, and your desire to make a difference in the lives of our patients. You are an inspiration to us.

Inspiration and tragedy walk hand-in-hand throughout our lives. We witness tragedy and feel its heartbreak. When it inspires us to extend ourselves in ways that help others, that’s when the beauty of our humanness emerges.

Daisy Award

Beginning this issue, we will be posting the names and photos of monthly DAISY Award winners as a regular feature in News & Views. See page 12 for our first award winners.
Moham Suntha, MD, MBA, is new UMMC President and CEO

Moham Suntha, MD, MBA, is the new president and CEO of UMMC, our two-hospital academic medical center comprised of University and Midtown Campuses. From 2012 to 2016, Dr. Suntha was president and CEO of the University of Maryland St. Joseph Medical Center.

Dr. Suntha first joined UMMC as a resident in the Department of Radiation Oncology in 1991. He has been a member of the faculty at the University of Maryland School of Medicine since 1995. Based on his clinical and academic accomplishments, he was awarded the Marlene and Stewart Greenebaum Professorship in Radiation Oncology in 2008.

He has assumed numerous administrative roles within the Medical System and School of Medicine. He served as the vice chairman and clinical director in the Department of Radiation Oncology, University of Maryland School of Medicine, and the associate director for clinical affairs in the Marlene and Stewart Greenebaum Cancer Center. In 2009, he was appointed vice president for system program development for the University of Maryland Medical System. In this role, he successfully leveraged the strengths of the University of Maryland School of Medicine faculty to address clinical needs across the Medical System.

Dr. Suntha earned his A.B. from Brown University in 1986 and his medical degree from Jefferson Medical College in 1990. He received his MBA from the Wharton School of Business at the University of Pennsylvania in 2009.

We look forward to Dr. Suntha's vision and partnership as he leads us forward in a spirit of alignment, transparency, and accountability. Together with our board of directors, Dr. Suntha will focus our collective efforts on the patient experience, employee engagement, financial stewardship, physician alignment, and community engagement.

Corporate Compliance

Andrea Alvarez, Compliance Specialist – Education and Training
Corporate Compliance and Business Ethics Group

In each issue, the Medical Center Compliance Program provides a short Frequently Asked Question (FAQ) for News & Views. We are looking for new ways to reach out to employees to raise awareness of compliance issues. Please let us know what you think, or suggest topics by emailing compliance@umm.edu or aalvarez1@umm.edu.

Compliance FAQ

Q: What happens after I report an allegation to the Corporate Compliance and Business Ethics Group (CCBEG)?

A: When an employee reports a potential violation of law or company policy to CCBEG, an investigation begins with an initial review. The case is then logged according to the UMMS affiliate involved and is assigned to one of the four CCBEG teams based on the nature of the allegation. All cases are handled confidentially and only discussed with those persons relevant to resolving the matter. If the case has been reported anonymously, we work with the information provided to investigate and substantiate the allegation to the extent that we are able.

continued on page 11.
High-Reliability Organizations: The Five Characteristics

Deborah L. Schofield, DNP, CRNP, FAANP, Director of Quality and Patient Safety and Mangla Gulati, MD, FAHS, CPPS, Vice-President and Associate Chief Medical Officer, Patient Safety and Clinical Effectiveness

As we continue on our High-Reliability Organizational (HRO) journey, it is essential to understand those characteristics which foundationally reflect such an organization. HROs are those organizations which have succeeded in avoiding catastrophes in an environment where normal accidents can be expected due to risk factors and complexity (Van Stralen, 2014). Essentially, an HRO expects its organization and its sub-systems will fail and works very hard to avoid failure, while preparing for the inevitable so that they can minimize the impact of failure (AHRQ, 2008). The classical sustainable examples of an HRO include aviation and nuclear industries. The best HROs anticipate that people will eventually make mistakes and their systems can become vulnerable. HRO principles help to build, thrive in, and sustain healthy safety cultures (AHRQ, 2008). Health care organizations are on the journey to becoming an HRO; some are further along the journey than others.

So what are the characteristics associated with an HRO? There are five principles of an HRO as identified by Weick, MD and Sutcliffe, MD (2013), who are principally responsible for the “mindfulness” that keeps an HRO working well when facing an unanticipated situation (Anderson Center for Health Systems Excellence, 2015). First, there is the preoccupation with failure. Again, HROs anticipate that people are fallible and that systems and processes can be vulnerable to failure. Employees at all levels are encouraged to both identify which processes are working well and to begin to analyze processes that may be susceptible to failure (Gamble, 2014). Once a process is identified as vulnerable in one area, it is important to extrapolate this to other areas which may be employing the same process to assess whether risk exists. It is important to note here that HROs encourage reporting of faulty processes and systems by employees, notably “de-stigmatizing” failure. Employees who report faulty processes and systems or medical errors are not punished in the just (fair) culture of an HRO.

The second HRO characteristic surrounds sensitivity to operations. Both leadership and staff need to maintain a constant vigilance and awareness of how processes and systems are affecting the organization (Gamble, 2014). HROs promote and encourage data sharing and constant operational awareness among employees at every level. One tactic to increase sensitivity to operations is to promote daily rounding in the place where the work is done; this allows employees and leadership to experience first-hand processes, which may be either burdensome and work is done; this allows employees and leadership to experience first-hand processes, which may be either burdensome and requires very well for them (Gamble, 2014).

The third HRO characteristic involves a reluctance to accept simple explanations for faulty processes or problems. An HRO, instead, digs deeper for the root causes of the problems and resists accepting simple explanations for identified problematic processes or systems. It is important to remember that explanations for identified problems, which may seem obvious, need to be further investigated as, often, an alternative cause for the problem may turn out to be the real source (Gamble, 2014).

Deference to expertise is the fourth characteristic of an HRO. This means that an employee at any level, with the most experience with a problem, process or task, should be consulted on the issue at hand. Leaders are encouraged to consult front-line staff regularly to solicit their opinions on identified problematic issues, no matter where the employees fall in the hierarchy of the organization (Gamble, 2014).

The fifth HRO characteristic includes resiliency of an organization. This involves being both relentless in how to respond to failures and creative in exploring and finding new solutions to problems. Although failures are anticipated, HROs are characterized by their rapid response to avoid catastrophic outcomes and development of new solutions to prevent these failures. The classical example is the “search for the black box” and the mobilization of a SWOT team to the site of an airplane crash every time (Chassin & Loeb, 2013).

How does health care differ? Often in health care, the collective health care team fails to bring their concern of unsafe conditions, practices and behaviors to attention. One might ask why this is? Poor communication, inadequate transitions of care, multiple hand-offs, and unnecessary hierarchies are often the reasons cited. When caregivers come to expect poor communication, they become desensitized to its hazards. In one analysis, such a culture of low expectations explained a substantial number of errors that led to continued on page 11.
Twenty-five students were selected to participate in the program. The majority were former students of itWorks Learning Center, Inc., and are currently working as certified nursing assistants and geriatric certified nursing assistants (CNA/GNA) in local nursing facilities. Each candidate was vetted by Ruth Borkoski, BSN, RN, nurse manager, Medical IMC and 13 East/13 West; Simone Odwin-Jenkins, MBA, BA, BSN, RN, nurse manager, Gudelsky 5 East - VSPCU; Patricia Wilson, MA, BSN, RN, FCN, clinical practice and development coordinator, Clinical Practice and Professional Development; Mildred Yarborough, MS, RN, senior educator and clinical instructor, itWorks Learning Center, Inc.; Jo-Ann Williams, MS, director of community and workforce engagement; Vicki Wrisk, BSN, RN, supplemental staffing; and Joshua Kanoff, human resources recruiter. This program is designed to train experienced CNAs/GNAs within the community and advance their current skills to work in a hospital facility. They learn the following competencies for a patient care technician (PCT):

- Cultural competence and inclusion in health care
- Computerized documentation (EPIC)
- Communication/conflict and stress management
- Infection control
- Pathophysiology of organs of the human body
- Systems review and the disease processes
- Patient safety
- Clinical skills and special procedures

On July 8, 2016, 18 of the 25 students successfully completed the program. The PCT closing ceremony took place in the Medical Center auditorium. Family, friends, and UMMC staff celebrated as the participants received their certificates and other awards. Greetings were given by Dana Farrakhan, MHS, FACHE, senior vice president, strategy and community and business development, UMMC; and Karen Doyle, MBA, MS, RN, NEA-BC, FAAN, senior vice president, nursing and operations, R Adams Cowley Shock Trauma Center. Vanzetta James, MS, MBA, RN, CCRN, nurse manager, Multi-Trauma Intermediate Care 6, Trauma Acute Care, and Orthopaedic Acute Care, delivered the congratulatory address. Mildred Yarborough, MSN, RN, itWorks, presented the awards. Morton Lapides, president of itWorks and Janet Palmer, MA, M.Ed., provided the closing remarks.

On July 13, 2016, all eighteen students passed their patient care technician exam and are now nationally board-certified patient care technicians. Many of them (see names below) are now employees of the Medical Center.
Beginning this issue, we will be posting the names and photos of monthly DAISY Award winners as a regular feature in *News & Views*.

The DAISY (Diseases Attacking the Immune System) Award was established by The DAISY Foundation in memory of J. Patrick Barnes, who died at 33 of ITP, an auto-immune disease. The Barnes family was awestruck by the clinical skills, caring, and compassion of the nurses who cared for Patrick and created this international award to say thank you to compassionate nurses everywhere. UMMC has made the decision to join the DAISY Foundation and recognize our most caring and compassionate nurses with this honor.

DAISY awardees are selected from nominations generated by patients, families, or co-workers. Individual nurses, teams, or nursing leaders are all eligible for the DAISY Award. The UMMC DAISY steering committee is a sub-committee of the Staff Nurse Council and will review all nominations and select a DAISY awardee every month. We will celebrate and honor each awardee in a public and special way. DAISY awardees are nationally recognized and respected for their ability to transform patient care through their compassion.

**DAISY Award Winners**

**MAY**

*Ty Schoppe*, BSN, RN, CNII
NeuroTrauma Critical Care Unit

**JUNE**

*Rachael Martin*, BSN, RN, CPN, CNII
Pediatric Acute Care

**JULY**

*Tim Kane*, BSN, RN, CNII
Neuro Intensive Care Unit
2016 Student Nurse Residency Program

Cyndy Ronald, BA, Manager, SON Partnership Programs

The University of Maryland Medical Center’s (UMMC) Student Nurse Residency Program has just completed its tenth year. This highly competitive program has been a valuable recruitment tool for top new graduate nurses at the Medical Center – over 83% of last year’s residents have been hired as new graduate nurses. The summer internship places students entering their senior year of nursing school on units ranging from adult medical to critical care in a variety of specialties, to include pediatrics. This year the Lung Rescue Unit participated in the program and accepted one student nurse resident. During the program, the residents work one-on-one with a nurse preceptor (three 12-hour shifts/week), attend bi-weekly education sessions, complete journals, and develop an evidence-based poster for presentation in the Weinberg Atrium on July 28th and 29th.

The interview process was held in March which included participation in a group discussion about an article sent to them prior to the interview. After this group discussion, the students were then taken to the computer lab where they were given a writing assignment and had 30 minutes to respond. Over 130 students took part in the process and 52 students were selected. Even though students selected are Maryland residents, they represented 15 different nursing schools in the country.

The students started on May 23rd and after one week of hospital and residency orientation, worked for nine weeks on their unit of placement. Through their sessions with mentors from Clinical Practice and Professional Development, feedback from preceptors and journal entries, it is exciting to report that each of the residents learned a great deal during their time at UMMC and have grown in their skills and confidence toward becoming a competent, safe, and compassionate nurse. The unit staff, preceptors, senior leadership, and other clinicians that the students interacted with, embraced them, supported them, and offered multiple opportunities for learning. Because of this incredible experience, the students feel they are well on their way to transitioning from student to new graduate nurse and will emulate the positive professional behaviors they witnessed. They were especially grateful for their preceptors and the amount of time they took to teach and challenge them every shift. At the end of the program, many of the students transferred to student nurse positions until graduation.

We are extremely proud of this group of student nurse residents. The following are some excerpts from their last journal entries speaking to the UMMC culture and their experiences.

continued on page 7.
2016 Student Nurse Residency Program, continued from page 6.

**Kelli Blue, NeuroTrauma Critical Care**  
*University of Maryland School of Nursing*  
I am so appreciative of this experience for helping me gain more confidence and allow me to explore my areas of strengths and weaknesses. I am thankful for my preceptor as well as the other nurses on the unit for helping me in this endeavor. They have taught me and guided me as I practiced developing new skills and were all readily available and willing to help me learn and practice skills. This experience has only made me more excited to become a nurse and I cannot wait to see what next semester and the future has in store for me.

**Liz Fordyce, Medical ICU**  
*University of South Carolina*  
I really have learned that sometimes nursing isn’t about helping all of your patients get better, but sometimes it’s about making death a beautiful part of life and easing the suffering as much as you can. I think that having learned this thought process, I can much more easily handle the kinds of patients that I have seen on this floor and know that I will be able to apply that thought process to my future as a nurse.

I have learned the most valuable lessons this summer, and look forward to my future as an RN with excitement, confidence, and pride. I have loved everything about UMMC and am so glad to have been at a teaching hospital that cares so much about all of their employees, including their students.

**Adam Warth, Cardiac Critical Care**  
*University of Maryland School of Nursing*  
Needless to say, my time in this program has taught me a lot about myself. My preceptor, Tara Daniels, BSN, RN, is a great role model and I feel fortunate that I had the privilege to work alongside her. She’s taught me to treat my patients like they were my family and to advocate for them to receive anything that might enhance their care. With her, I’ve learned what it really means to preserve my patients’ dignity: to care for their emotional, as well as their physical well-being. In my humble opinion, the knowledge, fine attention to detail and work ethic she brings to the CCU rate her as one of the top nurses in the CCU. They are extremely fortunate to have such a great nurse and person in their midst. I am sad to be leaving a unit where I have found myself at home for the past two months. However, I am pursuing a student nurse position on the CCU. They are extremely fortunate to have such a great nurse and person in their midst. I am sad to be leaving a unit where I have found myself at home for the past two months. However, I am pursuing a student nurse position on the CCU.

**Kattrina Merlo, Labor & Delivery**  
*University of Maryland School of Nursing*  
I will really miss working on the floor and following my preceptor, Morgan Leighton, BSN, RN, all over the place. I learned so much over the past couple months and Morgan was so patient and upbeat with me. I’m sure at times it would have been faster if she had been alone but she was also so willing to let me try things, congratulate me on things I had done well (even sending me encouraging text messages), answer all my questions, teach me what different things meant, quiz me on my strip assessments, and ask me questions why certain outcomes happened. She was also great at finding new experiences for me and getting many things crossed off my bucket list. Even today, we set up a delivery cart because it was something on my list that we still hadn’t had a chance to do. This was such a great experience and I am so happy I was able to spend the summer on the labor and delivery floor with her.

**Dolly Bindon, Medical IMC**  
*University of Maryland School of Nursing*  
I’ve never had a job that has challenged me in such diverse ways. It has challenged my knowledge, my teamwork skills, my critical thinking, my emotional intelligence, my negotiation skills, my prioritization and flexibility, and my organizational skills. It has challenged me physically, mentally, and emotionally, and yet I am excited every day that I get to spend the rest of my career only getting better and learning more.

**Adam Flanick, Medical ICU**  
*Towson University*  
The ten-week summer nurse residency program is now coming to a close. I cannot believe it. This summer has literally flown by. As I reflect on this past summer, I am amazed at how much I have learned and how I have grown. I started out lacking confidence in many of my nursing skills, assessment skills, and communication skills. Although I have in no way mastered these skills, I have become more competent and confident in my abilities to perform them. I have learned to manage my tasks, take initiative, and plan out my duties. I have seen growth in myself, especially in the last two weeks of this program. During these final two weeks, my preceptor has pushed me to do my best and take complete charge of the responsibilities and duties of the nurse. She has allowed me to work independently under her supervision so that I could act and react to situations on my own. This, by far, has been one of the greatest opportunities for growth this entire summer. When I realized that I was not simply taking part in the care, but rather taking charge of the care, I had a greater sense of responsibility and purpose in my actions.

continued on page 8.
Finally, I’ll end with the biggest lesson I learned (or, more accurately, relearned) this summer. It is human nature to jump to conclusions about someone, even when we hardly know anything about that person. However, nurses must be especially aware of this instinct and refrain from indulging in it. We see people at both their best and worst. However, we often see them at their worst before we see them at their best. Pain and suffering have a tremendous effect on a person’s demeanor.

It is essential that we never take personally the things that our patients say to us when they are feeling their worst. That isn’t to say we don’t do everything in our power to help them feel better. Simply put, we must consistently make a conscious effort to imagine our challenging patients in a healthier state. If possible, it helps to ask their family and friends to share their stories of the patient. However, I need to learn how to listen to such stories while simultaneously completing a full assessment and hanging multiple IV fluids.

Sarah Connolly, Labor & Delivery
Notre Dame of Maryland University

As I enter the final week of this program, I cannot help but reflect. The time has truly flown by and I am sad to see this amazing experience come to an end. My time in the labor and delivery unit this summer cannot be summed up in just a few words. I have seen a newborn take their very first breath, heard their very first cry, and held them in my arms when they open their eyes for the very first time. I am privileged enough to partake in the most important day in many peoples’ lives and witness some of their most personal and intimate moments.

Throughout this program I have learned so much about this incredible field and my place within it. Now I could tell you about all of the knowledge that I have gained and the skills that I conquered, but that it not what obstetric nursing is truly about. Down to its core it is about something a whole lot deeper. It’s about holding the hand of an anxious patient as they travel down this scary new road to a whole new life. Labor and delivery nurses have a very special relationship with their patients – one that involves a level of trust not always seen in other specialties. We are their guide throughout their labor. We have the answers to their questions. We have the words of encouragement offered in their time of need. ♦
The MASTRI Center –
High-Fidelity Simulation at UMMC

Katie Gordon, MSN, RN, CNE, Simulation Educator

The Maryland Advanced Simulation, Training, Research, and Innovation Center, otherwise known as the MASTRI Center, is located on the 7th floor of the South Hospital. We have added new staff and now have three simulation educators/training specialists: Kerry Murphy, DVM; Katie Gordon, MSN, RN, CNE; and Maggie Ryan, MS, RN. The Center allows staff and students the opportunity to experience real-life scenarios in the safety of the simulation environment. The activities are formative in nature – there is no pass or fail and they are intended to better prepare staff for emergency situations which may occur on their unit.

If you have identified an educational need that would be best served by the creation of a simulation-based training scenario, you can schedule a meeting with one of the educators to help create an individualized training activity to best meet the needs of your staff. They will help to determine what type of simulation is best for your unique situation. This could be a low-fidelity simulation that would include skills stations and role playing. Or, perhaps, maybe you require a higher-fidelity educational experience that would include use of the SimMan3G manikin. The simulation experience provides the kinesthetic learner the opportunity to really put their “hands on” the patient to learn in an active manner. Whatever your educational goal, the educators in the MASTRI center will help you achieve them in a safe, low-pressure environment.

This is a wonderful resource which is available to you and all UMMC clinical staff. We welcome the opportunity to work with new graduates, seasoned nurses, or multidisciplinary groups and introduce them to the simulation learning environment.

If you would like to meet with one of the MASTRI Center educators to discuss the possibilities available to you, please call 410-328-8428 and our administrative assistant, Rose Drayton-Trudge, will connect you with one of the educators. We look forward to meeting with you!
Building MyPlate: Connecting Patients and Families with Knowledge and Resources

Leahandra Wendland, RD, CSP, LDN, Nutrition Specialist for the Children’s Heart Program

We know that many of our patients who work and live in Baltimore City encounter barriers that prevent them from making the best food choices. Unfortunately, the grocery store and where our patients and families actually buy food are often two very different places. To maximize opportunities for making sound food selections and to minimize the disparity of where food is purchased, a team from the Children’s Heart Program at UMMC decided to create a nutrition program: Building MyPlate. The goals of this program are twofold: (1) to provide real-life application to concepts taught in the clinic setting, and (2) to teach patients and families about resources to help guide them in making healthy food selections. Building MyPlate became a reality through a partnership with this UMMC team and Shoppers Food and Pharmacy.

Creating a Partnership
When selecting a store with which to partner, it seemed to be in the best interest of our community to choose a community-based grocery store. Shoppers Food and Pharmacy has more locations than any other supermarket within the Baltimore City limits. We set up a meeting to propose our idea to Shoppers’ leadership and their goals were an identical match to ours: improving quality of life through providing nutritional educational opportunities and connecting patients and customers to resources. With that, a partnership was formed.

Getting Participation and Staffing the Event
Our team primarily reached out to patients and families within the Children’s Heart Program, but we also included those from the pediatric gastrointestinal practice. A total of 42 people RSVP’d “yes” to our Building MyPlate program. On the day of the event, we had 16 participants from five families, equaling a 38% turnout rate. Representatives from Clinical Nutrition Services: pediatric dietitians and dietetic interns; and Pediatric Cardiology: a cardiologist, nurse manager, QI coordinator, sonographers, and medical assistants, provided staffing for the program.

Our Event
To help make the participants feel welcome and get them excited about this nutrition program, we kicked off our event with an interactive dance video from the website, “GoNoodle.” Using this video gave us the opportunity to highlight the importance of physical activity. With the safety of playing outside being a concern for our community, we were able to show parents an alternative way to get their children active. Once the participants warmed up and were feeling relaxed, we discussed Building MyPlate. We encouraged audience participation by asking everyone to share favorite foods from each food category: protein, grain, fruits/vegetables, and dairy. We then discussed the nutrition facts label and showed a video from the Food and Drug Administration illustrating the importance of paying attention to this information when selecting foods to eat. Next, we discussed the usual layout of a grocery store and how to visit the healthier sections around the perimeter vs. the middle sections. We then moved on to talk about cost, debunking the myth that healthier food is more expensive. We examined both the nutritional and financial cost of building one’s own lunch vs. buying a pre-packaged lunch and of making one’s own oven fried chicken vs. buying a fried chicken meal. Once the classroom component of the session was completed, each family started at a different part of the "grocery store," represented by a food group. At each station, a volunteer discussed specific foods from the food group, comparing and discussing labels and how to find the healthier options. Once everyone went through each food group station, we asked participants to choose the food item they thought had a specific nutrient just by looking at a photo so as to reiterate the importance of label reading. Then, we held a question-and-answer session.

continued on page 11.
Clinical Nutrition, continued from page 10.

session and a “finish your shopping,” during which time families were able to take home the donated food items that had been used as examples. For home use, each family was given nutrition education materials and heart-healthy recipe booklets, highlighting foods discussed during the session.

Outcomes and Barriers
Feedback from attendees was overwhelmingly positive. As families were leaving, we had comments such as, “This was much more than I expected.” The best feedback came from an attendee who stated, “We’ve been attending your nutrition workshops; when is the next one?” Based on the survey we gave to families, everyone reported that they learned something new at the workshop. In addition, all stated they would attend another workshop in the future. Upon making follow-up phone calls, some of the barriers to attending were noted to be: sporting events for other children, one or both parents working late and sick children at home. To combat attendance issues in the future, we plan to reach out to as many people as possible in person and continue to offer great incentives for participation.

Looking Forward
Survey results showed the most frequent request was to have a session about proper portions and portion control. In the fall, we plan to continue our partnership with Shoppers Food and Pharmacy by bringing participants to one of their nearby locations for a grocery store tour. We hope to incorporate portion control and ethnic foods into the upcoming event. Our intent is to further our goals of reinforcing healthy eating principles and connecting our families to community resources.

Corporate Compliance, continued from page 2.

If you provide your contact information for follow-up, we may reach out for clarification and assistance in our investigation. When appropriate, UMMS management, Human Resources, the Office of General Counsel, or other designated individuals may be involved in the investigation and resolution of the case.

If the case involves Protected Health Information (PHI), the patient(s) may be notified with a letter providing brief details of the incident and what steps have been taken to remediate the issue. However, the identity of the employee who reported the incident or committed the violation is not disclosed to the patient. The government requires that HIPAA cases be resolved within 60 days of when the hospital or covered entity was notified or discovered the allegation. Therefore, it is very important that UMMS employees report concerns promptly to CCBEG.

All cases are reviewed by the affiliate compliance officer and/or CCBEG directors to ensure that all identified allegations are fully investigated, resolved, and when necessary, remediated.

See policy “CCI201 Procedures for Managing Compliance Incidents” on the intranet for more detailed information regarding this process.

High-Reliability Organizations, cont’d from page 3.

a patient undergoing an invasive procedure that was intended for someone else (Chassin & Loeb, 2013).

The three essential domains of an HRO are leadership; a culture of safety, where all are comfortable speaking up where safety is of concern; and continuous robust process improvement. UMMC is on the road to becoming an HRO. It is an evolutionary journey which engages and empowers all members of the health care team. ◆

References
The purpose of this research article was to determine if high-volume (HV) centers are more efficient at delivering endovascular approaches for patients with large vessel occlusion in acute ischemic strokes compared to low-volume (LV) centers.

The investigators hypothesized that patients treated with endovascular therapies at HV centers have lower times from CT scan acquisition to groin puncture, lower procedural times, and higher reperfusion rates than LV centers. This was a retrospective analysis of 442 consecutive patients treated with endovascular therapy at nine tertiary stroke centers from September 2009 – July 2011. Patients with anterior circulation large vessel occlusions were included and presented to the hospital within eight hours of symptom onset. Data was collected regarding demographic, radiographic, and angiographic variables and assessed by multivariate analysis to determine if HV centers were quicker at delivering care. A HV center was defined as one that performed fifty or more endovascular procedures a year. This was the median across the nine participating centers. The Department of Neurointerventional Radiology at UMMC was one of the nine centers that participated in this study.

Baseline characteristics between HV and LV centers were compared using the Fisher exact test for categorical variables and the Student t test or Mann-Whitney U tests, as appropriate. Secondary analysis was performed comparing patients with good clinical outcomes to those with poor outcomes and predictors of successful reperfusions. In both analyses, variables with a p value < 0.02 were entered into the multivariate binary logistic regression model to determine independent predictors of a good clinical outcome and successful reperfusion.

Results showed that there was no statistical difference with regards to age, use of the National Institute of Health Stroke Scale (NIHSS), location of thrombus, and hemorrhage rates between the HV and LV centers. HV centers performed better than LV centers from CT scan to groin puncture (OR 0.991, 95% CI 0.989 to 0.997, p=0.001), and total procedure times (OR 0.991, 95% CI 0.986 to 0.996, p=0.001). Patients treated at HV centers had better clinical outcomes (OR 1.86, 95% CI 1.11 to 3.10 p< 0.018) and successful reperfusion (OR 1.82, 95% CI 1.16 to 2.86, p< 0.008). HV centers treated more patients transferred in to their institution than LV centers (64% vs. 31%, p< 0.001). HV centers were more likely to treat patients after receiving IV tPA (48% vs. 38%, p< 0.04).

Based on the results, the authors concluded that HV centers perform endovascular procedures more efficiently than LV centers for acute stroke patients. These patients have a higher rate of reperfusion and better clinical outcomes post-procedure. Recommendations include implementation of future studies that focus on providing more efficient treatment to endovascular stroke patients. These studies should be prospective, focusing on each step in the treatment process and creating parameters that reduce time to treatment.

Study limitations were identified as follows:

- **Time of day that patients were treated not assessed.**
- **Unable to consistently capture the time of hospital arrival which coincides with treatment onset.**
- **Patients may have been enrolled in studies which can cause delays due to protocol and consent requirements.**
- **Imaging was interpreted by each center instead of an objective body.**

**Discussion:**

The golden rule for stroke patients equates to, “time is brain.” In treating strokes at a large tertiary hospital that is also a designated comprehensive stroke center, it is important to understand and improve the delays that can occur in patient flow from diagnosis to reperfusion after an acute ischemic stroke caused by an occlusion in a large vessel. This is essential to achieving better clinical outcomes for patients. Multidisciplinary collaboration is vital in achieving quicker treatment for patients. This is significant to nurses as they are involved at every time point of care. From admission through post-procedural care, nurses can help improve efficiencies.
in the sequence of events needed to treat this patient population.

The journal club members found this article, including the literature review, relevant and timely since UMMC is a Certified Stroke Center and captures procedure data on this patient population. The members strongly agreed that the citation from Neurology (2009) was significant to this study: “Time delays to reperfusion impact clinical outcomes. For every thirty-minute delay in reperfusion, there is a 12% decrease in the probability of good clinical outcomes.” (Khatri et al., 2009) This supports how the UMMC nurses in the Neuro Interventional Radiology department can impact the care of stroke patients from admission through intervention by ensuring timely treatment. The use of Certified Stroke Center metrics to justify the time points also helped to contribute to the validity of the study. Most agreed with the limitations of the study but some identified that the sample size of this study might not be reflective of the number of patients treated each year. Overall the members were interested in learning that UMMC is a Certified Stroke Center and is continuing to capture data to improve patient outcomes.

References

Our own artist-in-residence in the Pediatric Intensive Care Unit

Mary Jo Simke, MS, BSN, RN, Nurse Manager, Pediatric Intensive Care Unit

Think of how stressful it is for you or a loved one to be in a hospital – whether it be for outpatient surgery, a visit to the emergency department, or admitted to an inpatient unit. Now, close your eyes and imagine the patient is a child, and you are a parent, grandparent, friend, or sibling of a child who is hospitalized. Add to this the many unfamiliar noises (beeps, emergency bells), the visits from strangers (staff from the hospital), and the fear of painful procedures. This is what someone will most likely experience as part of the daily life in the Pediatric Intensive Care Unit (PICU) at UMMC. This is the reality for many patients and families of children (infants to young adults) who are cared for in the PICU for a day, a week, a month, and sometimes, for a year.

When one shares with others that they work in a PICU, the first question often asked is “How can you be around critically ill children every day?” Over the years, my answer has been that these children and parents are going to have to face their illness, no matter what, and if I and the nursing team can help them in any way, then we will do so knowing that the rewards will far outweigh the difficult times.

Many of our PICU colleagues contribute to bringing some kind of normalcy and cheer to our patients, families and staff. One notable staff member, Tamesha Bell, CNA, has a unique talent for doing so. Unbeknownst to her colleagues, we discovered very recently that Tamesha is a talented artist!

Tamesha started working in the PICU at the end of 2015. In the late winter/early spring of this year, when the unit was quieter, Tamesha was found to be drawing child-friendly cartoon characters on the glass doors of the patients’ rooms. Several parents had commented on how the drawings helped to brighten the PICU. Moreover, one could also see how these drawings were helping to provide a pleasant distraction for our patients; by focusing on them they could tune out, at least temporarily, the strangeness and unfamiliarity of this ICU environment. Thanks Tamesha for helping to cheer the lives of so many – particularly our patients – in the PICU.
Pediatric and Neonatal Respiratory Therapists
Strive for Commitment to Service Excellence, Communication, and Team Collaboration

Elshadie Ramdat, MHA, RRT-NPS; Greg Ludvik, MS, RRT-NPS; Paul Johnson, RRT; and Hamid Reza, RRT

The pediatric and neonatal respiratory therapists are key members of the Neonatal and Pediatrics Intensive Care Unit teams. Their roles are very broad and differ from one institution to another. At the University of Maryland Medical Center, the therapists work in the ICUs, labor and delivery, the acute care areas, and the pediatric emergency room and are also actively involved in research and patient and family education. Over the years, the respiratory therapy group has enhanced this service area by continuing to demonstrate excellent customer service, communication, and team collaboration.

Elshadie Ramdat, MHA, RRT-NPS, pediatric respiratory supervisor, acknowledged that, “The effort and the amount of support provided by respiratory care leadership, Chris Kircher, MHA, RRT-ACCS, director of respiratory care, and respiratory care managers, Robin Smith, BS, RRT and Oswald Murray, MHA, RRT, together with the pediatric supervisory team, enables the respiratory therapists (RTs) to provide high-quality patient care that has made a significant difference.” This positive patient care involvement has been recognized by many. The 52-bed, Level-4 NICU (the highest level NICU designation) at UMMC is unique in many ways. Our patients are often here for prolonged periods of time and have the most advanced respiratory support technology available to keep their lungs healthy.

According to experts, a new baby is born every eight seconds in the United States (Minority Nurse Staff, March, 2013). In our NICU, the respiratory therapists are part of the multidisciplinary team that attends all high-risk deliveries. Almost all therapists are Neonatal Resuscitation Program (NRP) certified and are actively involved in the resuscitation process, where they systematically assist with difficult intubations. It is through this collaborative effort that many babies with challenging disease processes are safely delivered. We just finished our NRP re-certification process of our entire pediatric respiratory therapist team with our very own NRP instructors, Wendy Riggin, BS, RRT-AEC from night shift and Kathleen Slater, RRT-NPS from day shift. Our entire team greatly appreciates their commitment to their service area and their efforts in making this program a success. The NRP course was detailed and included reading, testing, and multiple hands-on simulation training in our high-tech simulation lab.

As Dina El Metwally, MD, PhD, associate professor and medical director of the Drs. Rouben and Violet Neonatal Intensive Care Unit stated, “The consistent pool of NICU/PICU dedicated respiratory care practitioners in the NICU has improved the communication with the NICU primary care providers. Our respiratory care therapists are integral to the care of the fragile population of the NICU. They are NRP qualified and are present at the neonatal resuscitations for assessment and prompt intervention, especially the golden hour for infants < = 32 weeks, where right beginnings dictate good outcomes. I am glad to see our RTs at the bedside morning rounds, and it is a practice that I would like to emphasize in importance, as their suggestions, shared experience, and brainstorming over respiratory management is indispensable. I also would like to acknowledge the respiratory care leadership’s proactiveness, continuous support 24/7 and timely responses to the emerging challenges. Kudos!”

The respiratory therapists are deeply involved and invested in the I-STAT process in both the NICU and PICU. The supervisory team is in close contact with the point-of-care team under the direction of Laboratory Services, to offer complete, fast, and accurate laboratory testing. Many other areas of the Medical Center utilize I-STAT capabilities for quick testing. However, in the pediatric and neonatal settings, the therapist running the I-STAT tests allows for an instantaneous collaboration with the ICU team and more immediate changes for our sickest patients. Our involvement has been crucial in the process of testing the continuous renal replacement therapy (CRRT), priming blood
to ensure the electrolyte balance is suitable for small infants and children. Once the electrolyte values are obtained, they are used by the department of nephrology to fine-tune the patient’s dialysis therapy.

The respiratory therapists are also involved in running activated clotting time (ACT) I-STAT tests for pediatric extracorporeal membrane oxygenation (ECMO), which monitors the effects of heparin on clotting time. These values allow for the ECMO specialist and physician to adjust various settings on the ECMO pump to keep this intervention running smoothly. The respiratory therapist may have to run these tests every hour to guide the physician’s treatment plan.

The pediatric group understands and embraces the importance of effective communication and team collaboration in order to provide the best in patient care. Therefore, as part of our team’s initiatives, the therapists are involved in different committees within respiratory care service and with other multidisciplinary groups. For instance, The Critical Review Improving Safety and Processes (CRISP) is a PICU initiative where respiratory care is substantially involved. It is an opportunity for respiratory therapy to be a part of an exciting collaborative team approach where health care providers do their absolute best to improve and engage in best care practice.

According to PICU nurse manager Mary Jo Simke, MS, BSN, RN, “The pediatric respiratory therapists are an integral part of the daily care provided to patients and families being cared for in the PICU. Therapists partner with providers and nurses to plan and deliver individualized care to the patient, whether it be assisting intubated patients to walk, taking technology-dependent babies on a stroller ride within the unit, or teaching parents to care for children who will be discharged with a newly placed tracheostomy and ventilator. Partnerships have been formed at the unit level where staff and leadership participate in standing unit meetings focused on improving the patient experience, discussing safety, and making changes to improve future processes, developing protocols, and teaching new physicians and nurses vents, oxygen delivery, etc."

Paul Johnson, RRT, pediatric respiratory supervisor, states that “Being part of this team collaboration has been an excellent experience not only by actively participating in this meeting, but also learning and seeing different practices. Working with such an enthusiastic group of individuals with the common goal of safe practice and working to help our patients in the PICU is so enlightening and well-respected. Being able to bring ideas and partake in this experience is just amazing.”

Having the very talented and focused respiratory therapy group has facilitated our involvement in research. One of our biggest accomplishments this year has been to complete our first pediatric abstract entitled “Intrapulmonary Percussive Ventilation’s (IPV) Assist in Weaning Pediatric Patients from ECMO.” This abstract was well-prepared and written by Maria Madden, BS, RRT-ACC, interim education supervisor, Deborah Linehan, BS, RRT-NPS, Jason Custer, MD, Elshadie Ramdat, MHA, RRT-NPS, and Paul Johnson, RRT. The article has been accepted by the American Association for Respiratory Care (AARC) Journal and will be presented by Linehan and Ramdat at the 2016 Maryland Respiratory Care State Conference. The rationale behind the research is important because there are no published studies to support this therapy for the pediatric population. The therapists took the initiative to do our internal research to validate whether or not the treatment is, in fact, effective.

The pediatric and neonatal team will continue to strive to provide compassionate care for our children and families in need. It takes all of us working together as a team to accomplish our common goals. We will embrace our strength, core values (teamwork, communication, collaboration, accountability, ownership, and respect), and work on our differences together to push forward for continued distinction in the field of respiratory care.

Reference
Pharmacists Join UMMC Brain Attack Team in Response to Alerts of Inpatients with a Suspected Acute Ischemic Stroke

Michelle C. Hines, PharmD, Clinical Specialist, Emergency Medicine, Department of Pharmacy Services

“Time is brain” – swift intervention is essential to restoring cerebral blood flow and preserving brain tissue in patients with an acute ischemic stroke (Jauch et al., 2013). The use of intravenous (IV) recombinant tissue plasminogen activator (rtPA) is associated with neurologic improvement and better outcomes when given early to patients with an ischemic stroke – the effect of rtPA on recanalization may decrease as time progresses (Jauch et al., 2013; Muchada et al., 2014).

The decision to administer rtPA involves weighing the potential benefit of recanalization against the risk of bleeding, including intracranial hemorrhage. The 2013 American Heart Association/American Stroke Association (AHA/ASA) stroke guidelines recommend that patients eligible for IV rtPA receive treatment as quickly as possible given this time-dependent benefit to rtPA therapy (Jauch et al., 2013). These guidelines provide a treatment window of within three hours of symptom onset, and this treatment window may be extended to 4.5 hours in certain patients who do not meet additional exclusion criteria.

Target: Stroke is an AHA/ASA quality improvement initiative which aims to achieve door-to-rtPA time of <60 minutes in patients who present with suspected ischemic stroke who are eligible to receive rtPA (Fonarow et al., 2011). This initiative has identified 10 best practice strategies (see Table 1).

The inclusion of pharmacists in the stroke team may augment strategies 7, 8, and 9. In fact, a recent study showed a shorter door-to-rtPA time when a pharmacist was present at emergency department stroke calls compared to when a pharmacist was not present (Gosser et al., 2016).

The UMMC Code Stroke Committee meets quarterly to identify areas for improvement in the management of patients who receive rtPA for the treatment of a suspected acute ischemic stroke. To minimize delays in rtPA administration due to elevated blood pressure, this group recently authored a guideline for blood pressure management in patients with acute ischemic stroke being considered for fibrinolytic therapy. Elevated blood pressure (systolic >185 mmHg or diastolic >110 mmHg) is listed as an exclusion criteria for rtPA treatment (Jauch et al., 2013), and as many as 15% of acute ischemic stroke patients who present to the emergency department have elevated blood pressure (Qureshi et al., 2007). This blood pressure management guideline was approved at the May 2016 UMMC Pharmacy and Therapeutics Committee meeting, and its implementation is anticipated to help facilitate the safe and timely utilization of rtPA in hypertensive patients.

To further improve the management of inpatients who develop an acute ischemic stroke at UMMC, pharmacists on the Code Blue Team will now be joining the UMMC Brain Attack Team in responding to alerts of inpatients with a suspected acute ischemic stroke. The pharmacist’s role as part of the Brain Attack Team will be to assist the team with implementation of the blood pressure management guideline when indicated and to facilitate the timely procurement, preparation, and safe administration of rtPA. The pharmacy department looks forward to our new role in helping improve the acute management of inpatients with an acute ischemic stroke.

References

Table 1

<table>
<thead>
<tr>
<th>Target: Stroke best practice strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Advance hospital notification by EMS</td>
</tr>
<tr>
<td>2. Rapid triage protocol and stroke team notification</td>
</tr>
<tr>
<td>3. Single call activation system</td>
</tr>
<tr>
<td>4. Stroke tools</td>
</tr>
<tr>
<td>5. Rapid acquisition and interpretation of brain imaging</td>
</tr>
<tr>
<td>6. Rapid laboratory testing (including point-of-care testing if indicated)</td>
</tr>
<tr>
<td>7. Mix rtPA medication ahead of time</td>
</tr>
<tr>
<td>8. Rapid access to IV rtPA</td>
</tr>
<tr>
<td>9. Team-based approach</td>
</tr>
<tr>
<td>10. Prompt data feedback</td>
</tr>
</tbody>
</table>
University of Maryland Medical Center, in collaboration with Johns Hopkins Hospital, presents:

MARYLAND
COMPREHENSIVE
Stroke
Conference 2016

Friday, November 11, 2016    7:30 am – 2:30 pm

Turf Valley Resort
2700 Turf Valley Rd.
Ellicott City, MD 21042

For more information,
call 410-328-6257 or email
professionaldevelopment@umm.edu

11th annual
NURSE PRACTITIONER & PHYSICIAN ASSISTANT
CLINICAL
CONFERENCE

NOVEMBER 16, 2016    7:30 am – 5:00 pm

University of Maryland, Baltimore
Southern Management Student Campus Center

For more information, call 410-328-6257 or email professionaldevelopment@umm.edu
Peer-reviewed publications and presentations by Patient Care Services staff. Notifications of Acceptance July 1, 2015 through June 30, 2016 Congratulations to accomplished staff!

**PUBLICATIONS**


**Corbitt, N.** (2015). Chapter Communications. Oral Presentation at the Oncology Nursing Society Leadership Weekend, Pittsburgh, PA.


**continued on page 15.**
Publications and Presentations, continued from page 14.


McComiskey, C. (2015). Research, Evidence-Based Practice or Quality Improvement – That is the Question. Keynote Address, Nursing Research Conference Shore Health Medical Center, Cambridge, MD.


Change in Allergy Wristbands: Effective August 1, 2016

Background:
To ensure patient safety, UMMC will transition to a new allergy armband to simplify and standardize the patient allergy identification process. The new band will be consistent with the following American Hospital Association (AHA) recommendations:

- Red band with bold ALLERGY alert, indicating “Stop” or “Danger.”
- Bands should omit handwriting/specific allergy lists to avoid transcription errors or issues with legibility. Our electronic health record provides a comprehensive list of allergies, and is updated with new allergies identified during hospitalization.

How will this impact nursing staff?
- Nursing will no longer handwrite/list specific allergies on patient allergy armbands.
- Nursing will place a red allergy alert armband on patients with identified allergies upon admission. Beginning August 1st, the new product will be utilized for new admissions.
- All clinicians will refer to the electronic health record to review and update patient allergies.
- Outpatient/procedural staff will place an allergy armband if a patient is latex-allergic and requiring a procedure, or when medications or radiopharmaceuticals are administered during the visit.

What else do I need to know?
- New bands will be stocked on unit par.
- When necessary, clinicians will refer to paper Ticket to Ride to review allergies during transport.
- In the event of an electronic health record downtime, downtime documents are inclusive of patient allergy information.

Please review policy COP-020 (Go-Live 8/1) for more information.
For questions, contact Kara Stevens at kstevens1@umm.edu