Maryland Patient Safety Center's
Statement on
OHCQ's Maryland Hospital Patient Safety Program Annual Report FY23

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The recently-released Maryland Office of Health Care Quality's (OHCQ) Maryland Hospital Patient Safety Program Annual Report for FY23 includes statistics that show a higher number of significant patient safety events being reported by hospitals in Maryland. This report comes at a time when several recent studies show an overall improvement in certain patient safety and quality measures, as evidenced by the Leapfrog Group, the American Hospital Association, and the Maryland Health Care Commission. These are not incompatible, as a strong culture of safety and reporting is also an important part of overall improvement.

Patient safety event reporting in Maryland is one part of the State's innovative strategy to optimize the quality of care available to Marylanders. The Maryland Patient Safety Center applauds hospitals' self-reporting of- and learning from—patient safety events, not unlike what occurs in other industries to improve safety. The Office of Health Care Quality has appropriately encouraged Maryland hospitals to increase their self-reporting to promote shared learning and improvement. Indeed, recent clarifications in thresholds for reporting has given hospitals the opportunity to report and learn from a wider scope of events. Thus, the number of reported events demonstrates the State's commitment to patient safety and learning, a positive safety culture, and hospitals' commitment to transparency and learning. Just like with other industries, the safest organizations are those with the strongest reporting records; when hospitals report safety events, it demonstrates the ability to improve outcomes. We must learn from them, and work to ensure they do not keep happening. These data cannot be easily compared year-to-year due to changes in reporting certain events; and the data cannot be easily compared with other states for similar reasons. That said, improving patient safety and eliminating preventable harm needs to be a top priority for hospitals in Maryland.

The Maryland Patient Safety Center applauds the decrease in reported pressure injuries as a result of concerted efforts and learning. The Maryland Patient Safety Center is also a federally-designated Patient Safety Organization, which allows healthcare organizations to share, explore, and learn from patient safety issues in a protected environment. The Maryland Patient Safety Center is providing additional resources and programs to support healthcare organizations in their collaborative improvement efforts, harnessing the synergy in numbers. We will work with hospitals and others in the healthcare system to address all preventable harm, with significant focus on those areas identified in the OHCQ report, including patient falls, medication safety, pressure injuries, and delays in treatment. We are also working with Maryland healthcare organizations to build their workforce capacity for the work of patient safety.

The Maryland Patient Safety Center is participating with the Maryland Department of Health and OHCQ on a new innovative initiative to collaborate to address the safety issues identified and submitted by Maryland hospitals. We also continue to explore opportunities for increased collaboration on improvement. Reducing preventable harm requires a concerted, persistent, coordinated effort by all stakeholders, and a total systems approach to safety.