Making Research Findings Work in Practice

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Evacuation from Lower Manhattan
An estimated 2.2 million commuters were in New York City on a normal working day in 2001. With the collapse of the second (North) World Trade Center tower on September 11, most of the hundreds of thousands of commuters, as well as other workers, residents, and transients in the area, were blocked from leaving by the usual land routes. Streets were clogged with debris, and public transportation had ceased operations. Given the polluted and suffocating air, these people retreated south, many as far as the seawalls at the tip of Manhattan.

At around 11 AM, a massive evacuation by a large number of boats and other vessels that had converged on the seawalls and a few docks in the area began. The ferries, tour and dinner boats, and private pleasure craft that normally carry passengers were joined by far more vessels—such as tugs, outboard runabouts, pilot boats, and oil-spill response vessels, a Coast Guard cutter, and even a retired fire boat—that were never intended to carry passengers.

The massive convergence of boats and other vessels was triggered in part by a radio call, “All Available Boats,” issued by the local Coast Guard on VHF 13 and 16 after the collapse of the North tower. The call requested anyone with a vessel in the area to go to the shoreline of lower Manhattan, but it appears that much of the convergence also resulted from personal observations or knowledge that an evacuation by water craft was possible or being attempted. The Coast Guard, which swiftly responded to the attack by establishing a security cordon around lower Manhattan, notified vessels such as ferries with which it had regular everyday contact that safety and accident rules and regulations did not need to be strictly followed. But it seems that many of the converging vessels had little direct interaction with the Coast Guard that day.

Photos and films of the evacuation show thousands of civilians waiting calmly in line and helping one another to climb down into craft of all sizes and shapes at the base of high seawalls, as well as into the few vessels at docking facilities. Two of the photos published in an account of the evacuation are shown on pages 317 and 318.* The scene was reminiscent of the evacuation of more than 300,000 British and French soldiers at Dunkirk during World War II, which involved a similarly massive but unorganized convergence of an armada of craft large and small, operating mostly on their own.

Although some thought had been given to circumstances that might require evacuation via bridges and tunnels around Manhattan, there had been no planning for this scale and kind of organizational activity. No group was

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responsible for making such an activity a central part of its disaster planning. No organization or official was in complete charge of the overall emergent evacuation activities. Who went where, where evacuees were disembarked in New Jersey or Staten Island, and how long any vessel operated, were decisions often made independently by the multiple operators of different vessels who had little direct communication with one another or agencies elsewhere. The Coast Guard did suggest that some tugs go to particular docks in lower Manhattan, but this was an atypical guidance effort in the situation, especially in the evacuation’s early stages. The larger number of vessels from the private sector operated intermixed with vessels from the public sector. This combination of vessels required informal cooperation to avoid collisions and to take turns in picking up evacuees because overall control of the water traffic could not have been imposed. However, when the vessel traffic at certain localities became very heavy, in one part of the bay a port captain of a major private shipping company informally took over on his own initiative as an unofficial waterfront coordinator. (There was apparently another similar occurrence in another part of the waterfront.)

The Evacuation’s Success

By any criteria, the evacuation was an extremely successful endeavor. There appear to have been no fatalities or casualties in the operation; no vessel was involved in any accident. According to the Coast Guard, in the course of about 6 to 7 hours, perhaps up to 500,000 persons were moved. Later estimates have sometimes reduced the figure to around 300,000. Both totals seem reasonable, given that one ferry company alone counted transporting 158,502 evacuees.

It is difficult to see how the overall evacuation effort could have been conducted more effectively. What could have been done to better attain the implicit collective goal of transporting the evacuees from Manhattan? In fact, on the basis of our knowledge of how disaster planning is frequently resisted, we can say that any attempt to preplan such an evacuation would have immediately been met with a variety of objections, such as the following:

- Persons cannot be put on a boat in excess of its authorized capacity or on one not built to carry passengers;
- People cannot be picked up at high seawalls because potential evacuees will panic or fight one another to get on approaching boats; or
- Ignoring everyday marine and port rules and regulations will create potential lawsuits.

Fortunately, in the actual crisis of September 11, people and groups rose to the occasion, doing what needed to be done to cope with new and unexpected problems.

The kind of emergent behavior shown in the evacuation was in an important sense familiar to veteran disaster researchers. Studies of evacuation at times of crises, which have now been undertaken for 50 years, have consistently shown that at times of great crises, much of the organized behavior is emergent rather than traditional. In addition, emergent evacuation is often decentralized, with the dominance of pluralistic decision making and the appearance of imaginative and innovative new attempts to cope with the contingencies that typically appear in major disasters. Fortunately, on September 11 no attempts were made to impose a command and control model on the evacuation by water transport from lower Manhattan.

We should note that there were two nearly concurrent activities on that day at the World Trade Center which also showed the social patterns that disaster researchers would have expected. One was the largely successful evacuation of the surviving occupants of the towers and surrounding

* A command and control model is a highly centralized and top-down organizational structure in which higher-echelon personnel have formal authority to issue orders to subordinate personnel.
buildings. The other was the initial (but not the later) search and rescue undertaken right after the collapse of the North tower. Neither activity was controlled by anyone. Instead, both of these emergent responses showed many nontraditional features. The individuals and small groups involved showed considerable flexibility and initiative in dealing with the drastic challenges that the massive physical destruction created for survivors.

The success of the decentralized response to the crisis of September 11 as described does not argue against preimpact disaster planning. In fact, to disaster researchers just the opposite is clearly indicated—namely, that good preplanning should explicitly indicate to any organization that might become involved during the emergency period of a disaster that command and control models will not work. Instead, things can be done to encourage group and individual responses that make sense in a crisis. Just making crisis planners conscious of the fact that there will be considerable emergence of new behaviors and decentralization of decision making will discourage trying the impossible and will facilitate realistic disaster management. Acting on wrong assumptions can be totally dysfunctional for good planning and managing.

The Coast Guard has far more legal authority over New York harbor than most organizations have over their territories. But this organization, intelligently, made no effort to take over the evacuation, which had primarily started on its own. Instead, it provided as much relevant information as it could to facilitate as much as possible the new decentralized behavior that emerged. The Coast Guard essentially played a supportive rather than a directive role. The specific reasons as to why the Coast Guard demonstrated such appropriate and laudable behavior deserve study, but at the very least what happened shows that even organizations used to operating in a highly structured framework can change their operations to better adapt to a very new kind of major crisis.

Implications

Anyone involved in health care might consider the implications of the nature of the evacuation of lower Manhattan for emergency preparedness and emergency management activities. What unexpected problems might occur in a major disaster? What sort of crises might particularly require new kinds of organized responses? What sort of nontraditional resources (people and/or things) might be potentially available for emergencies? What preplanned steps might be taken to facilitate such new organized behavior that might emerge? How can pluralistic decision making be made effective in new kinds of crises? What traditional or standard crisis management procedures or structures might not be very effective for new kinds of crises? We believe that if medical and hospital personnel consider the implications of the evacuation of lower Manhattan, they will be able to generate answers to these questions and other relevant questions that will be very helpful in crisis planning and management. Of course for that to occur, they will have to think outside the traditional box.

This article was adapted from a commentary, “Who Was in Charge of the Massive Evacuation of Lower Manhattan by Water Transport on September 11? No One Was, Yet It Was an Extremely Successful Operation. Implications?” which appeared in the Sep/Oct 2002 issue of Securitas, the newsletter of the Suburban Emergency Management Project in Lisle, Illinois (www.ben.edu/semp).

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New Ways to Measure the Value of Disease Management

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Strategies to Prevent Suicide in Health Care Organizations

Using a multifaceted approach to suicide prevention

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About the Book
Health care organizations today are grappling with health care–associated infections, the threat of bioterrorism, and the emergence of new and unprecedented diseases such as SARS and West Nile Virus—all significant and challenging issues that can impact patient safety and the delivery of quality care. Meeting JCAHO’s Infection Control Requirements: A Priority Focus Area illustrates the growing crisis in infection control across the spectrum of health care organizations and how compliance with the Joint Commission’s infection control standards can provide a solid structure and foundation to tackle key infection control issues.

Coinciding with the release of the Joint Commission’s new infection control standards and the new infection control-related National Patient Safety Goal, this book provides timely and helpful information on the standards and their elements of performance, provides examples of compliance for all types of health care organizations, and includes a comprehensive description of the newest National Patient Safety Goal related to the reduction of health care–associated infections. Also featured is a foreword written by Dr. Dennis O’Leary, President of the Joint Commission on Accreditation of Healthcare Organizations.

About Joint Commission Resources
Joint Commission Resources, Inc. (JCR), is a client-focused, expert resource for health care organizations. It partners with these organizations, providing consulting services, educational services, and publications to assist in improving the quality, safety, and efficiency of health care services and to assist in meeting the accreditation standards of the Joint Commission. JCR is a not-for-profit affiliate of the Joint Commission but provides services independently and confidentially, disclosing no information about its clients to the Joint Commission or others. Visit our Web site at http://www.jcrinc.com.
CHAPTER 4

Developing an Effective Infection Control Program: Challenges and Tips for Success
As discussed in Chapter 2, “The Joint Commission’s Infection Control Standards and Requirements: A Detailed Study,” the Joint Commission’s infection control (IC) standards place a strong emphasis on the development, implementation, and evaluation of an integrated and responsive IC program. Establishing such a program helps to preserve patient and staff safety and prevent adverse events. However, just because an organization creates an IC program, does not necessarily mean that it is effective.

The goal of an IC program is to identify and reduce the risks of acquiring and transmitting infections among individuals served, staff, contract service workers, volunteers, students, and visitors. Effective IC programs have several facets, including the following:

- Involvement of the entire organization
- Have been designed, implemented, and supported by leadership
- Inclusion of the appropriate number and mix of trained staff to implement IC procedures
- Continuous surveillance and data collection activities to identify and reduce organization risk for infections
- Periodic evaluations to make sure that prevention efforts are working

Although all these components are crucial to an effective program, they are not always easy to achieve. The purpose of this chapter is to identify some challenges associated with the development of an effective IC program and provide tips to overcome those challenges. Some of the recommendations are not required by the Joint Commission although the relevant Joint Commission standards are included for reference in the form of a standards link as shown below.

### Involving the Whole Organization

**IC.1.10 The risk of development of a health care–associated infection (HAI) is minimized through an organizationwide infection control program.**

The risk of infection occurs throughout a health care organization, and any program designed to control and prevent infection must involve all areas of an organization to be effective.

### Creating Multidisciplinary Teams

One way to involve all areas of an organization is to create a multidisciplinary IC team, task force, or formal committee that is charged with creating, implementing, and monitoring the IC program. Although the Joint Commission does not specifically require the creation of a multidisciplinary committee, the use of one can be helpful in developing and maintaining an effective IC program. In fact, some organizations exist in states where licensure law, rules, or regulations specify an IC committee.

A multidisciplinary IC group, committee, or team should be broadly inclusive of all related departments and all major clinical service areas, including but not limited to the following (as applicable):

- Central sterile processing
- Environmental services
- Equipment maintenance personnel
- Facilities management, including engineering and maintenance personnel
- Finance
Examples of Compliance: Pain Assessment and Management
Assessment is critical to providing quality care. To determine the care appropriate to meet an individual’s needs, the individual must be assessed when he or she is admitted to the organization and reassessed throughout his or her stay.

**Relevant Standard**

One standard in the Assessment chapters of Joint Commission accreditation manuals focuses on pain assessment. It simply states that pain is assessed in all individuals receiving care. A more comprehensive assessment of pain is needed if, during the initial screening for pain in all individuals, organizations identify individuals with pain. The goal of an initial assessment is to identify the individual with pain and to characterize his or her pain by intensity and quality (for example, pain character, frequency, location, and duration). Long term care organizations are specifically required to include in the initial assessment an assessment of the pain’s origin, location, severity, alleviating and exacerbating factors, and current treatment and response to treatment.

When the individual is experiencing pain, he or she can be treated in the organization or referred for treatment. The scope of pain treatment provided is based on the care setting and services provided. A more comprehensive assessment is performed when warranted by the individual’s condition. The assessment and measure of pain intensity and quality, appropriate to the individual’s age, are recorded in a way that facilitates regular reassessment and follow-up according to criteria developed by the organization.

**Pain Assessment Basics**

Pain assessment is the essential first step in pain management. Without a thorough, baseline pain assessment, appropriately managing pain is impossible. Assessing the person in pain involves asking the person about his or her pain and accepting what the person reports. This acceptance is the foundation for a therapeutic alliance between the caregiver and individual. A good assessment is more than a form. It is a way of thinking. The individual’s self-report of pain is the most reliable indicator of the existence and intensity of pain. Hence, the individual’s report should be the primary source of information. However, as noted by June Dahl, PhD, professor of pharmacology at the University of Wisconsin, Madison, Medical School and cofounder of the Wisconsin Cancer Pain Initiative, pain assessment is much more than producing a number on a numeric pain scale. It is about improving quality of life and functional status. Individuals should be asked about how pain interferes with their daily life—does it affect their sleep? their ability to enjoy friends and family? their ability to work?

The two steps of pain assessment are screening for pain and, if pain is identified, conducting an in-depth assessment. Essential elements of pain assessment include intensity, location, quality, temporal characteristics, aggravating and alleviating factors, present pain regimen and effectiveness, pain management history, effects or impact of the pain, meaning of the pain, individual goals and expectations, and a physical exam/observation of the site of pain. Intensity is one of the most important elements. Organizations must establish and use a rating scale appropriate for the population. They also must document pain intensity...
About the Book

Failure Mode and Effects Analysis in Health Care: Proactive Risk Reduction will help your organization examine your processes for possible ways in which failure can occur. This book advocates proactive, prospective error prevention in health care. Proactive identification and management of potential risks to patient safety have the obvious advantage of preventing adverse occurrences, rather than simply reacting when they occur.

Failure Mode and Effects Analysis (FMEA) is a systematic way of proactively examining a process for possible ways in which failure can occur. The technique involves identifying potential failures before they happen and determining whether the consequences of those failures would be tolerable or intolerable. Potential failures are identified in terms of failure “modes” or symptoms. This book includes the following:

- Real examples of FMEAs conducted by health care organizations;
- Clear and helpful summaries, tips, and definitions; and
- Links to relevant JCAHO requirements and initiatives.

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Chapter 2

Select a High-Risk Process and Assemble a Team

This chapter addresses how health care leaders can select which high-risk process or processes would most benefit from FMEA. It begins by describing the types of processes that should be considered and outlines the characteristics of such processes, such as their complexity, lack of standardization, dependence on human intervention, and other factors. The chapter provides information on the sources health care leaders can use to identify the processes most critical to safety and overall performance improvement and most in need of FMEA.

Next, the chapter covers how leaders assemble the best possible FMEA team appropriate to the selected process. Because FMEA must be a team-oriented activity and cannot succeed without being so, the chapter outlines how leaders assemble a top-notch team and consider such issues as team size, composition, training, and roles. The chapter also addresses the scope of the FMEA, how it is defined and by whom, and the use of definition and mission statements to provide initial and ongoing clarity and consensus. Finally, FMEA team boundaries are covered, including such topics as responsibilities, resources, deadlines, and communication.

Characteristics of High-Risk Processes

What are the characteristics of high-risk processes? A review of the definition of process could be a helpful starting place. As described in Chapter 1, a process is “a systematic series of actions directed to some end.” It is a goal-directed interrelated series of events, activities, actions, mechanisms, or steps that transforms inputs into outputs. Richard J. Croteau, MD, and Paul M. Schyve, MD, of the Joint Commission dissect this
About the Book

Root Cause Analysis in Health Care: Tools and Techniques, Second Edition updates and explains the Joint Commission’s framework for conducting a root cause analysis (RCA) on adverse events, near misses, and unexpected outcomes. This new edition includes:

- An increased focus on multiple and interrelated root causes;
- Updated terms and definitions;
- Tips from reviewers who conduct reviews of sentinel events and RCAs;
- Updated versions of the following: the Joint Commission’s Sentinel Event Policy, Minimum Scope of Root Cause Analysis Table, and Framework for a Root Cause Analysis Action Plan; and
- Discussion of RCA’s relationship to failure mode and effects analysis (FMEA).

Root Cause Analysis in Health Care: Tools and Techniques, Second Edition provides step-by-step instructions on how to:

- Complete a thorough, credible root cause analysis and acceptable action plan that meet current Joint Commission requirements;
- Collect data and interpret analysis results;
- Develop, implement, and monitor an action plan for improvement;
- Assess the effectiveness of risk-reduction efforts;
- Integrate root cause analysis with performance improvement programs; and
- Adapt and apply sample forms, charts, diagrams, and tools for use in root cause analysis efforts.

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Root Cause Analysis

in Health Care

Tools and Techniques

Second Edition

Improving Health Care Quality and Safety
Chapter 3
Preparation for Root Cause Analysis

This first workbook chapter describes how to prepare for a root cause analysis. It covers organizing a team, defining the problem, and studying the problem. The information is presented in a practical and user-friendly way. To help illustrate the steps of root cause analysis, sentinel events involving a suicide, elopement, treatment delay, and medication error are described as examples throughout this and subsequent chapters. A description of each incident of a sentinel event appears in Sidebar 3-1, pages 46–47. Checklists and worksheets are presented throughout the chapter. Use this and the remaining three chapters as a workbook—fill in the blanks.

A sentinel event or a near miss has occurred in an organization. Leadership has been informed and, in the case of an actual sentinel event, an organization has completed preliminary response procedures, including ensuring patient safety, risk containment, and prevention of repeat action (see Chapter 2, pages 35–37). The appropriate staff members have documented the event and ensured communication with appropriate stakeholders.

**Step One: Organize a Team**
The first step involved in conducting a root cause analysis might be to assign a team to assess the sentinel event or potential sentinel event. Leaders must lay the groundwork by creating an environment conducive to root cause analysis and improvement through team initiatives. Often, leaders will need to assure staff that organization improvement through the identification and reduction of risks, rather than the assignment of blame, is the objective.
ACCREDITATION STANDARDS FOR
HUMAN RESEARCH PROTECTION
AND
INDEPENDENT REVIEW BOARDS

Effective Date May 2003
Two seemingly contradictory goals?
Not any longer, thanks to *Cost-Effective Performance Improvement in Hospitals*. Hospitals are under increasing pressure to cut costs while consistently maintaining or improving the quality of care, treatment, and services provided.

This book helps hospitals deal with this pressure by offering practical tools and valuable lessons based on the Joint Commission's performance improvement (PI) standards. This book uses the standards to guide organizations through an effective improvement process while saving money and staff time and streamlining resources. *Cost-Effective Performance Improvement in Hospitals* describes a comprehensive model that teams can use today to select, measure, and incorporate changes to improve care, treatment, and services. Case studies are based on actual experiences in successfully improving performance while at the same time using resources judiciously and cost-effectively. The book walks the reader through designing a cost-effective PI project, creating a successful PI team, designing issues to improve and measure, assessing and analyzing data, and implementing and maintaining change.
Joint Commission International (JCI) is pleased to present you with our first issue of *Joint Commission International Newsletter*. We look forward to offering you crucial information and tips on improving the quality of care in your own organization, updating you on new developments in our international accreditation programs, and providing a network for you to share and learn good practices with and from other organizations around the world.

Through both international accreditation and technical assistance, JCI works to improve the quality of patient care in many nations. What makes our accreditation program unique is its long-term commitment to quality improvement; it is more than a snapshot of a health care organization—it is a continual quality assessment and improvement methodology that enables an organization to strive for optimal achievable standards. In fact, we can see the evidence of that in our currently accredited health care organizations in such countries as Austria, Brazil, Denmark, Germany, Ireland, Italy, the Kingdom of Saudi Arabia, Spain, Thailand, Turkey, and the United Arab Emirates.

The year 2002 was a busy one for JCI. In addition to releasing our second edition of international hospital standards, we have also established new international accreditation programs for clinical laboratories and medical transport organizations. Important strides have been made in developing and identifying a set of international health care indicators, a move that leaders in international health care have embraced. The year 2003 will mark the implementation of these international indicators as well as the release of international standards in the care continuum.

JCI is also maintaining its commitment to quality improvement through its participation with the World Health Organization’s International HIV Treatment Access Coalition and its Working Group on Quality Control and Clinical Accreditation for ARV Therapy Providers. As part of this effort, JCI will work with the Council for Health Service Accreditation of South Africa (COHSASA) and the Institute for Hospital Quality Improvement and Accreditation (HA-Thailand) to implement a plan to develop comprehensive, internationally accepted, and evidence-based standards for improving the quality of health care delivery for people living with HIV/AIDS in developing nations. JCI has also been working through the QAP project with University Research Corporation Center for Human Services to provide technical assistance to the ministries of health in Zambia, Jamaica, Eritrea, South Africa, and Jordan to help improve the quality of health care provided to their citizens.

*Joint Commission International Newsletter* will report on special activities, share any policy or standard changes in JCI’s accreditation programs, and bring you any new or forthcoming quality improvement initiatives in the international health care arena. We hope it will become an indispensable tool as you seek ways to improve quality at your own health care organization. I encourage you to use this newsletter to keep up to date on JCI and to learn from your colleagues around the world. Through relationship-building processes such as this one, we make a commitment to share knowledge that will improve health care around the world. We at JCI look forward to building this partnership with you.
15 Seconds

About the amount of time it takes to sing the alphabet song. About how long it takes to sing “Happy Birthday to You.” The minimum amount of time you should wash your hands with soap and water to help prevent the spread of infections.
Don’t Gamble

Don’t gamble with your patients’ lives. Clean your hands before and after contact with patients and between procedures. When infections spread, everyone loses.