

Making Strides in Safety

From the hospital to all care settings:

Working together to improve care and prevent harm

The American Medical Association (AMA), as a strategic partner in the ongoing efforts of the Institute for Healthcare Improvement (IHI) to improve patient care, supports your continued participation in patient safety activities through the AMA Making Strides in Safety® program.

The AMA, in addition to supporting physician involvement in the IHI's newest initiative—"Protecting 5 Million Lives From Harm"—has created this toolkit of resources to help you improve care for *all* of your patients, in all settings of care. The IHI's newest initiative challenges American hospitals to adopt 12 changes, or interventions, in care to reduce current levels of morbidity (i.e., illness or medical harm such as adverse drug events or surgical complications) and mortality. Six interventions are original to IHI's first national initiative—the "100,000 Lives Campaign"—and six are new. The IHI also encourages participants to add their own changes in care, such as fall prevention—an intervention addressed in this toolkit.

"The leader needs to be where the line is the weakest, where leadership will create or influence the best results."



For more information on how the AMA is helping doctors help patients through its Making Strides in Safety program, visit www.ama-assn.org/go/makingstrides where you can download other toolkits in this series, view materials from the AMA that correspond to IHI campaign interventions and more.



Visit the IHI at www.ihl.org/ihl/programs/campaign and click the “Materials” tab for more information about the campaign interventions, including a how-to guide for each intervention.

IHI campaign interventions

Interventions from the “100,000 Lives Campaign”

- Deploy rapid response teams.
- Deliver reliable, evidence-based care for acute myocardial infarction.
- Prevent adverse drug events (ADEs) by implementing medication reconciliation.
- Prevent central line infections.
- Prevent surgical site infections.
- Prevent ventilator-associated pneumonia.

New interventions targeted at reducing harm

- Prevent harm from high-alert medications starting with a focus on anticoagulants, sedatives, narcotics and insulin.
- Reduce surgical complications by reliably implementing all of the changes in care recommended by the Surgical Care Improvement Project (SCIP).
- Prevent pressure ulcers.
- Reduce methicillin-resistant *Staphylococcus aureus* (MRSA) infection by reliably implementing scientifically proven infection control practices.
- Deliver reliable, evidence-based care for congestive heart failure to avoid readmissions.
- Get boards on board by defining and spreading the best-known leveraged processes for hospital boards of directors, so that they can become more effective in accelerating organizational progress toward safe care.

Making Strides in Safety suggested intervention: Prevent falls.

Campaign opportunities and strategies for physicians to improve patient care

The AMA appreciates your efforts and the strides you are making to improve patient safety. To help you make the most of the opportunities provided by the IHI campaign,

this toolkit offers strategies to improve patient care and outcomes. As you participate in the campaign, consider these strategies.

- Lead implementation of the campaign’s evidence-based interventions.
- Elicit systems support for the work at the front line of care.
- Advance improvement methodologies.
- Participate on teams.

About workarounds

A workaround can best be described as a detour around a recognized problem in a system. Most workarounds are quick, of-the-moment fixes when, in fact, an analysis of the underlying problem is needed *before* applying any solution.

Although workarounds can be creative and safe under the right circumstances, they may be so tailored to a specific situation or patient's need that they may not be reliable or sustainable. What works for one may not work for all. The underlying deficiency must be identified, communicated to all, addressed by the system and properly fixed. There must be a true solution to the problem.

Frequently workarounds can be highly creative and indicative of an individual thinking outside the box. At times, after analysis of the underlying problem, the workaround is the solution. However, skipping the analytical phase and accepting the workaround at face value can become a prescription for disaster.

Workarounds are demonstrative of real needs and should not be ignored or accepted as the “way we get things done around here.”

Your role: You are always on your patients' health care team—your patients need you.

Regardless of the degree of your interface with your hospital system, i.e., whether you are a member of the organized medical staff or an employed physician, you are always on your patient's health care team when your patient is admitted to the hospital for medical care. You are seen by your patients as the health care professional—whether as the primary care physician or a member of the hospital health care team—who is responsible for managing their care and keeping them safe.

Your role: Physician support is critical to the campaign's success.

Lead efforts to improve patient outcomes; patient care begins with your orders and your written plan of care.

- Review the goals of all the interventions.
- Become familiar with responsibilities and roles.
- Use evidence-based, patient-centric tools.
- Encourage your colleagues and peers to “own” the campaign; this is about improving the *medical care* your patients receive.

Elicit organizational support for your activities and for appropriate allocation of resources to improve quality and safety.

- Look at what you are being asked to do (e.g., medication reconciliation, infection control, other quality and safety interventions).
- Can you clearly see what needs to be done, and do you have resources to accomplish the goals?
- Be honest about your concerns and those of the health care team. Create opportunities where issues can be discussed and concerns addressed.

- Identify your organization's policy barriers, systems gaps, cultural boundaries, alignment of policy to quality and safety goals, and resources and needs.
- Assess your organization's system:
 - Are there multiple, contributing factors that pose barriers to your desired outcome?
 - Are you competing for limited resources?
 - Would you characterize your organization as supportive—that is, leaders in your organization understand what is needed at the point of care and provide the front-line resources (especially staff and time) needed to improve care?
 - > Do you see the proposed work plan as a “quick fix,” i.e., a temporary solution to a long-term problem, rather than an investment that produces the best systems change? (Beware of the quick fix!)
 - > Have you resorted to a “work-around” in the past to achieve a desired outcome?
- Identify resistance to change—in yourself and others.
- Become familiar with and use your hospital's communication protocols for all manner of communication—with teams, colleagues, clinical department leaders, chiefs or chairs of the hospital medical staff, administration, and the board of trustees.
- Report back to appropriate personnel (e.g., your team, colleagues, medical staff leadership, hospital management or trustees) regularly about progress or problems.



Advance safety and quality improvement.¹

- Assess where you are now and where you want to go.
- Articulate measurable goals.
- Become results-oriented; the goals are effective remedies that improve patient care.
- Define the means and methodology by which you will achieve your goals.
 - Consider all aspects of this process, especially the time needed to first unlearn and then relearn a new method of care.
 - Carve out time to routinely meet with your colleagues and team to discuss progress.
- Implement your plan—test, study and measure your results.
 - Identify what worked and what did not.
 - *Do not be afraid to learn from failure.*

Participate in team efforts to improve care. Patient safety is a team activity!

- Put your patient on the team. Your patient is a valuable member of the health care team.
 - The patient is the one constant across the continuum of care.
 - The patient is the only person on the team who knows how he or she feels, what medications he or she takes (or does not take), what resources and support are needed to reach his or her goals, and other important information.

- Listen to; partner, talk and share decisions with; and teach, mentor and support your patient.

- Create a learning environment where team members can candidly, but safely, exchange dialogue.
 - Inquire: Ask questions to get information from others.
 - Advocate: State your views and describe what you think.
 - Mentor or seek mentorship as needed.
- Get everybody on the same page.
 - Ask your colleagues and teammates: “What is your understanding of what we are being asked to do?”
 - Ask if everyone understands the reason for the need to change.
 - Ask: “What are your concerns?”
- Deepen your team’s commitment to the goals.
 - Strive for a shared vision, not merely conformity.
 - Agree to a common set of goals; align efforts.
 - Answer the question, “What are we trying to accomplish?”
 - Give the team access to information.
 - Share knowledge and best practices.
 - Encourage ownership of assigned tasks.
 - Provide affirmation—acknowledge the skills, knowledge, work and accomplishments of others.

“Practice the science of medicine as a team and the art of medicine as individuals.”

—J.L. Reinertsen, MD²

- Give everyone time to think.
 - Encourage time for creative thought and exploration.
 - Carve out time to discover, discuss and analyze the next best idea or explore new approaches to your work or procedures.
- Provide feedback frequently; communicate your results, as appropriate to:
 - The patient or the patient’s family or caregiver (don’t forget—the patient is on the team)
 - Physicians participating in your patient’s care
 - Teammates
 - Other teams, settings or sites of care
- Anticipate that not all communication will be objective. There may be times that members of the health care team will *speak and listen* subjectively rather than objectively. As you strive for common ground and mutual understanding, consider the following suggestions to enhance team communication and listening skills.
 - Initiate Situation, Background, Assessment, Recommendation (SBAR) for staff-to-staff communication. Improve staff communication with the SBAR tipsheet (available on the AMA Making Strides in

Safety Web site at www.ama-assn.org/go/makingstrides).

- Consider incorporating *critical language* into your SBAR scripts. Critical language alerts team members to unsafe situations:
 - > In advance, the team agrees to use direct, consistent critical phrases such as, “I am concerned” or “I am uncomfortable,” or critical words such as *unsafe*, *safety* or *scared* to convey an unsafe situation, a breach in protocol or a sense of discomfort.
 - > When a team member uses those phrases or words, other members of the team stop what they are doing, take a step back, listen and re-analyze the situation. No one proceeds until all agree it is safe to do so.
- Apply health literacy principles—“Safe Communication Universal Precautions”—when communicating with patients and their families or caregivers. Visit the AMA Making Strides in Safety site at www.ama-assn.org/ama1/pub/upload/mm/370/acceleratetoolkit.pdf to view tips for clear communication and improved patient understanding.



“It is better to build on what is working than to obsess about what is not working. It is easier to evolve the culture than to change it.”

—E.H. Schein³

About change and learning

The IHI campaign is about learning new ways to work and changing the way that work is done to further improve patient care

and keep patients safer. Consider the following statements about change and learning, as well as the attributes necessary for learning.

The learning journey

“Change requires learning.”
—D. Hutchens^{4(p54)}

“Learning is the process,
not the goal.”
—D.M. Berwick⁵

“Learners in supportive environments have high levels of self-efficacy and self-motivation and use learning as a primary transformative force.”
—C. Bereiter and M. Scardamalia⁶

“Organizations learn
when people learn.”
—D. Hutchens^{4(p57)}

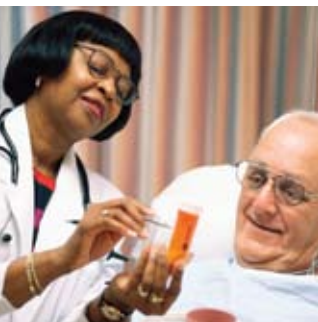


Attributes necessary for learning⁷:

- Personal mastery
- Collaboration and social interaction
- Systems thinking: understanding and addressing the whole organization; examining the interrelationship between components of the system; orienting perspectives toward the long-term view

Remember ...

- “Unlearning” is part of the learning process. Learning a new skill/method takes practice, patience and organizational policy that supports the learning process.
- A punitive learning environment breeds paralysis; fear of making mistakes restricts the learning environment to a narrow “safe zone.”



References

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3. Schein EH. Sense and nonsense about culture and climate. In: Ashkanasy NM, Wilderon CPM, Peterson MF, eds. *Handbook of Organizational Culture and Climate*. Thousand Oaks, CA: Sage Press; 2000: Xxiii–xxx.
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6. Bereiter C, Scardamalia M. Intentional learning as a goal of instruction. In: Resnick L, ed. *Knowing, learning, and instruction: Essays in honor of Robert Glaser*. Hillsdale, NJ: Lawrence Erlbaum Associates; 1989:361–392.
7. Crichton S. *Learning Environments Online: A Case Study of Actual Practice* [dissertation]. Sydney, Australia: University of Sydney; 1997. www.ucalgary.ca/~crichtos/doctorial_research.html. Accessed February 7, 2008.

“An organization cannot create a climate of teamwork and cooperation if it encourages individual competitiveness; participation and empowerment if ‘bosses’ own the work; or openness if it punishes messengers for bad news.”

—E.H. Schein³

Improving care

The following is the work of the American Medical Association (AMA), the AMA-convened Physician Consortium for Performance Improvement® (www.ama-assn.org/go/physicianconsortium), and the AMA's work with the Centers for Disease Control and Prevention, the Infectious Disease Society of America and the Institute of Medicine. This body of evidence-based work corresponds to interventions in the Institute for Healthcare Improvement (IHI) "Protecting 5 Million Lives From Harm" campaign, a national initiative that aims to improve patient safety and the care patients receive. Although the campaign is largely hospital-based, the care your patient needs may transcend multiple settings of care, in which case the materials can assist your efforts in both managing and coordinating care. In response to the IHI campaign's encouraging institutions to add their own improvement interventions to the campaign, many organizations have chosen fall prevention. Given the impact of patient falls on outcomes, work developed by the Physician Consortium for Performance Improvement is included to assist your efforts to prevent falls.

IHI campaign intervention	Corresponding materials from the AMA
<p>Prevent adverse drug events (ADEs) by implementing medication reconciliation.</p>	<p>Care coordination: Medication reconciliation (appropriate for ambulatory care setting only) <i>American Geriatric Society; Physician Consortium for Performance Improvement</i></p> <p>Making Strides in Safety®: The physician's role in medication reconciliation—issues, strategies and safety principles <i>AMA-convened expert panel</i></p>
<p>Prevent surgical site infections by reliably delivering the correct perioperative antibiotics at the proper time.</p>	<p>Perioperative care measures: Timing of prophylactic antibiotics; selection of prophylactic antibiotics <i>American College of Surgeons; Physician Consortium for Performance Improvement</i></p>
<p>Prevent harm from high-alert medications starting with a focus on anticoagulants, sedatives, narcotics and insulin.</p>	<p>Stroke and stroke rehabilitation: Overuse measure—avoidance of intravenous heparin <i>American Academy of Neurology; American College of Radiology; Physician Consortium for Performance Improvement</i></p>
<p>Reduce methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) infection by reliably implementing scientifically proven infection control practices.</p>	<p>Outpatient management of CA-MRSA skin and soft tissue infections <i>AMA; Centers for Disease Control and Prevention; Infectious Disease Society of America</i></p> <p>Alliance for the Prudent Use of Antibiotics FAAIR Report <i>AMA; California Medical Association</i></p> <p>Emerging infections <i>Institute of Medicine (1999)</i></p> <p>Outpatient parenteral antimicrobial therapy (OPAT): Intended for any physician managing the ongoing care of patients (of all ages) receiving OPAT in an office setting (i.e., not at home) <i>Infectious Disease Society of America; Physician Consortium for Performance Improvement</i></p>
<p>Deliver reliable, evidence-based care for acute myocardial infarction.</p>	<p>Emergency medicine measures <i>American College of Emergency Physicians; American College of Cardiology; American Heart Association; Physician Consortium for Performance Improvement</i></p>
<p>Prevent central line infections.</p>	<p>Anesthesiology and critical care: Prevention of catheter-related bloodstream infections—catheter insertion protocol <i>American Society of Anesthesiologists; Physician Consortium for Performance Improvement</i></p>
<p>Prevent ventilator-associated pneumonia.</p>	<p>Anesthesiology and critical care: Prevention of ventilator-associated pneumonia <i>American Society of Anesthesiologists; Physician Consortium for Performance Improvement</i></p>
<p>Deliver reliable, evidence-based care for congestive heart failure to avoid readmissions.</p>	<p>Heart failure measures <i>American College of Cardiology; American Heart Association; Physician Consortium for Performance Improvement</i></p>
<p>Other safety/quality intervention: Prevent falls.</p>	<p>Prevent falls <i>American Geriatric Society; American Academy of Family Physicians; American Academy of Orthopaedic Surgeons; American Association of Clinical Endocrinologists; American College of Rheumatology; Endocrine Society; National Committee for Quality Assurance; Physician Consortium for Performance Improvement</i></p>

Physician Consortium for Performance Improvement measures

Acute myocardial infarction (AMI)

Emergency medicine—professional resources and measures

www.ama-assn.org/go/consortiummeasures

Measure 1

Electrocardiogram Performed for Non-Traumatic Chest Pain (page 3)

Measure 2

Aspirin at Arrival for AMI (page 4)

Measure 3

Electrocardiogram Performed for Syncope (page 5)

Measure 8

Fibrinolytic Therapy Ordered within 20 Minutes of ECG Performed for AMI (page 10)

Measure 9

Care Coordination for PCI for AMI (page 11)

Congestive heart failure (CHF) or heart failure

Campaign focus on preventing readmissions

Heart failure—professional resources and measures

www.ama-assn.org/go/consortiummeasures

Surgical site infections (SSIs)

Perioperative care—professional resources and measures

www.ama-assn.org/go/consortiummeasures

Measure 1

Timing of Prophylactic Antibiotics—Ordering Physician (page 3)

Measure 2

Timing of Prophylactic Antibiotics—Administering Physician (page 5)

Measure 3

Selection of Prophylactic Antibiotics First OR Second Generation Cephalosporin (page 7)

Medication reconciliation (Med Rec)

Geriatrics—professional resources and measures

www.ama-assn.org/go/consortiummeasures

Measure 1

Medication Reconciliation (page 3)

Risk assessment for falls; plan of care for falls (Falls)

Geriatrics—professional resources and measures

www.ama-assn.org/go/consortiummeasures

Measure 6

Screening for Fall Risk (page 9)

Appropriate for all non-acute settings; excludes emergency departments and acute care hospitals

Osteoporosis—professional resources and measures

www.ama-assn.org/go/consortiummeasures

Ventilator-associated pneumonia (VAP)

Anesthesiology and critical care—professional resources and measures

www.ama-assn.org/go/consortiummeasures

Measure 1

Prevention of Ventilator-Associated Pneumonia—Head Elevation (page 6)

Central line-associated bloodstream infections (CLABIs)

Central line infections (CLIs)

Anesthesiology and critical care—professional resources and measures

www.ama-assn.org/go/consortiummeasures

Measure 2

Prevention of Catheter-Related Bloodstream Infections (CRBSI)—Catheter Insertion Protocol (page 9)



(Continued on page 10)

(Continued from page 9)

Physician Consortium for Performance Improvement measures	
<p>High-alert medications (High-Alert Meds) Campaign focus on anticoagulants, insulin, narcotics and sedatives</p>	<p>Outpatient parenteral antimicrobial therapy (OPAT) Intended for any physician managing the ongoing care of patients (of all ages) receiving OPAT in an office setting (i.e., not at home)</p>
<p>Stroke and stroke rehabilitation—professional resources and measures www.ama-assn.org/go/consortiummeasures</p> <p>Anticoagulants</p> <p>Measure 9 Overuse Measure—Avoidance of Intravenous Heparin (page 14) <i>For quality improvement only</i></p> <p>“Dose-adjusted, unfractionated heparin is not recommended for reducing morbidity, mortality, or early recurrent stroke in patients with acute stroke (i.e., in the first 48 hours) because the evidence indicates it is not efficacious and may be associated with increased bleeding complications (Grade B).</p> <p>“IV, unfractionated heparin or high-dose LMW heparin/heparinoids are not recommended for any specific subgroup of patients with acute ischemic stroke that is based on any presumed stroke mechanism or location (e.g., cardioembolic, large vessel atherosclerotic, vertebrobasilar, or ‘progressing stroke’) because data are insufficient (Grade U).”</p> <p><i>American Academy of Neurology; American Stroke Association</i></p>	<p>Outpatient parenteral antimicrobial therapy—professional resources and measures www.ama-assn.org/go/consortiummeasures</p> <p>Measure 1 Plan of care documentation at initial visit (page 4)</p> <p>Measure 2 Maintenance Visit—History (page 5)</p> <p>Measure 3 Maintenance Visit—Physical Examination (page 6)</p> <p>Measure 4 Laboratory Testing—CBC (page 7)</p> <p>Measure 5 Laboratory Testing—Creatinine or GFR (page 8)</p> <p>Table 1 Suggestions for parameters that should be monitored weekly during outpatient parenteral antimicrobial therapy (page 9)</p>



Resources, research and reports on infectious diseases

Methicillin-resistant <i>Staphylococcus aureus</i> infection (MRSA)	Antibiotics and antimicrobials	Emerging infections
<p>Resources/standards, medical science, infectious diseases, antibiotics pertaining to outpatient management of community-associated MRSA</p> <ul style="list-style-type: none"> • Outpatient management of community-associated MRSA skin and soft tissue infections www.ama-assn.org/ama/pub/category/18073.html • Outpatient management of skin and soft tissue infections in the era of community-associated MRSA (flier) www.ama-assn.org/ama1/pub/upload/mm/36/ca_mrsa_desk_102007.pdf <p>The AMA has collaborated with the Centers for Disease Control and Prevention and the Infectious Diseases Society of America to produce this informational flier to help facilitate outpatient management of skin and soft tissue infections in the era of community-associated MRSA infections.</p>	<p>Resources/standards, medical science, infectious diseases</p> <p>www.ama-assn.org/ama/pub/category/1863.html</p> <p>By providing links to different resources and news on antibiotics and antimicrobials, the AMA remains actively involved in important issues pertaining to antibiotics and antimicrobials.</p> <ul style="list-style-type: none"> • Alliance for the Prudent Use of Antibiotics FAAIR Report www.ama-assn.org/ama/pub/category/13733.html • Acute respiratory tract infection guideline summaries www.ama-assn.org/ama/pub/category/17892.html <p>The AMA collaborated with the California Medical Association Foundation’s “Alliance Working for Antibiotic Resistance Education (AWARE)” project, which addresses the issue of antibiotic resistance and the appropriate use of antibiotics in the Acute Respiratory Tract Infection Guideline Summary for adults and pediatric patients (www.ama-assn.org/ama1/pub/upload/mm/370/amaadultrti_summary.pdf or www.ama-assn.org/ama1/pub/upload/mm/370/ama_pediaticrtisumm.pdf).</p>	<p>Resources/standards, medical science, infectious diseases</p> <p>www.ama-assn.org/ama/pub/category/1949.html</p> <ul style="list-style-type: none"> • Emerging Infections: Microbial Threats to Health in the United States (report) <p>Published by the Institute of Medicine in 1992, this report highlights the many changing factors in the United States and global society that have allowed infectious diseases, once thought to be under control, to return as the third-leading cause of death in the United States and the leading cause of death in the world. These factors include societal changes, health care changes (such as the widespread use of antibiotics), the globalization of the food supply, changes in human behavior (such as international travel), the decay of the public health infrastructure and many other factors.</p> <p>The AMA will continue to provide physicians with current information and links to important issues in the world of emerging infectious diseases.</p>



What about HIPAA, the Privacy Rule?

The Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) allows covered *health care providers* (this term includes physicians) to share protected health information for purposes without patient authorization, as long as they use reasonable safeguards when doing so. These treatment communications may occur orally or in writing, by phone, fax, e-mail or otherwise.

Physicians are often concerned about violating HIPAA regulations when using the Internet or e-mail to discuss cases with other physicians, but the Privacy Rule requires that covered health care providers apply reasonable safeguards when making these communications to protect the information from inappropriate use or disclosure. These safeguards may vary depending on the mode of communication used. For example, when e-mailing protected health information, reasonable safeguards may include secure electronic transmission of identifiable patient information; adequate technical and physical security on the computer (e.g., strong passwords, password-protected screen saver and data encryption); and ensuring the computer is inaccessible to others.

To learn more, visit the U.S. Department of Health and Human Services at www.hhs.gov/hipaafaq and search “e-mail.”

Resources to help improve patient care: Enriching the learning environment by sharing information

To further support your efforts to improve patient care and outcomes, the following pages provide both general information and links to a variety of physician-developed resources.

E-mail and professional networks

For years, physicians used the doctors’ lounge as the location to meet and socialize, discuss cases, exchange ideas, or genuinely lounge. The lounge was a symbol of the profession’s collegiality where informal dialogue often evolved into serious learning sessions or curbside consults.

Today, face-to-face communication has been complemented by computer-mediated communication. Although informal opportunities exist to socialize and exchange information—such as in the cafeteria, during continuing medical education (CME) classes or on grand rounds—the virtual doctors’ lounge has become a new space where colleagues can interact, share practice information and capture the benefits of professional dialogue while diminishing the effects of professional isolation.

E-mail and professional networks:

- Expand the physician’s community
- Provide the ability to track down authoritative, evidence-based medical information
- Offer easy and convenient communication venues to time-strapped physicians

The virtual physician’s lounge

Sermo is an example of a specialized social Web network that brings together physicians nationwide who might otherwise never meet or have the opportunity to exchange ideas. Whether in solo, small or larger practices, physicians may access Sermo to interact or share information, bounce ideas off their colleagues, or get timely, informal second opinions. Sermo aims to capture the types of conversations doctors have face to face (e.g., at the point of care, in the hospital doctors’ lounge or cafeteria) and turn these discussions into valuable information.

Visit www.ama-assn.org/ama/pub/category/17614.html or www.sermo.com to learn more.

Patient-physician tools from the AMA

The AMA has compiled the following resources to help you strengthen the patient-physician relationship and improve patient care.

The patient-physician partnership for better health care and safer outcomes

The partnership between patient and physician is the hallmark of our nation’s complex health care system. When patients and physicians form a strong relationship based on mutual responsibility and trust, patients are more likely to be active participants in their own care. By working effectively with their physicians to form a partnership, patients increase their potential for achieving better, safer outcomes.

To promote stronger patient-physician partnerships, the AMA, in collaboration with AARP, presents a Web-based resource outlining responsibilities that patients and physicians can strive to meet through a shared commitment. A list of Internet resources that patients and physicians can access for more information also is included. Visit the AMA Making Strides in Safety site at www.ama-assn.org/go/makingstrides to access this tool.

Health literacy tools and resources

Through the AMA Foundation, the AMA is exploring the link between health literacy and patient safety. The goal is to create safer and shame-free health care environments not only for patients with limited health literacy but for all patients. Toward that goal, the AMA has created two resources—a patient safety monograph and patient safety tip cards—to help health care providers minimize communication-related adverse events.

- **Reducing the risk by designing a safer, shame-free health care environment**—this monograph offers new supporting research, explores how ineffective communication and low health literacy combine to affect patient safety, provides tools to decrease communication-related

adverse events at a systemwide level, and helps physicians initiate changes toward a safer and shame-free practice environment. Also included is CME credit for physicians, as well as a “Safe Communication Universal Precautions” tip card, which can serve as a take-away reminder of the tips featured within the monograph.

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this educational activity for a maximum of 2.5 *AMA PRA Category 1 Credits*[™].

- **“Safe Communication Universal Precautions” tip card**—this laminated, pocket-size card contains practical tips for providers on how to minimize communication-related adverse events.

Both of the above resources are supported in part by an educational grant from Pfizer Inc. and are available for purchase. Visit the AMA Foundation at www.ama-assn.org/amafoundation-healthliteracy and click the “Health literacy and patient safety” link to learn more about these tools and other health literacy resources from the AMA.



Physician-developed resources from the medical community

Central line infections

American Society of Anesthesiologists
Recommendations for infection control for the practice of anesthesiology (second edition)
www.asahq.org/publicationsAndServices/infectioncontrol.pdf

This document from the American Society of Anesthesiologists specifically addresses nosocomial and occupationally acquired infections as they correlate to the practice of anesthesiology.

Stefan Holubar, MD

Central line caveats
www.anastomosis.net/Interns%20Survival%20Guide/Central%20Line%20Caveats%20v1.htm

Dr. Holubar offers suggestions from experienced, front-line operators for preventing serious complications during central line insertion and removal. From the novice to the expert, all will appreciate his step-by-step walk through the procedure, especially his attention to the human factor skills necessary to increase central line expertise.

David C. McGee, MD, and Michael K. Gould, MD

Preventing complications of central venous catheterization

N Engl J Med. 2003;348(12):1123–1133.
<http://content.nejm.org/cgi/content/full/348/12/1123>. Accessed January 27, 2008.

Doctors McGee and Gould explain methods for reducing the frequency of complications in adult patients. This article is enhanced by detailed illustrations of catheter insertion. Additionally, the authors provide an algorithm analysis and guidance for management of a suspected catheter-related bloodstream infection.

Video-based training for central line insertion

Web-based and online training videos have the potential to complement central line catheter clinical educational experiences. However, researchers caution that video simulations, although deemed valuable, may not capture the complexity of actual clinical practice. You may find value in using the videos as examples of technique and stimuli for discussion. The following will link you to various central line insertion training videos.

- **David C. McGee, MD,
and Michael K. Gould, MD**
New England Journal of Medicine
Preventing complications of central venous catheterization
<http://content.nejm.org/cgi/content/full/348/12/1123/DC1>
- **Nicholas Johnson, MD,
and David Howes, MD**
University of Chicago Hospitals
EM Procedures: Tips and Tricks for the Emergency Medicine Practitioner

Vascular Access: Central Line Placement

- Part 1: Central Line Basics
www.youtube.com/watch?v=6KHM-IVF5Ek
- Part 2: Central Line Basics
www.youtube.com/watch?v=sUzMvLYyERI
- Part 3: Central Line Basics
www.youtube.com/watch?v=lUx-jLjGT10
- Part 4: Central Line Basics
www.youtube.com/watch?v=Ge2iQxWjH4w
- Part 5: Placing a Femoral Central Line in a Pulseless Patient
www.youtube.com/watch?v=nPnyXlhMpvA



- **Hennepin County Medical Center**
Department of Emergency Medicine
Ultrasound Guided Central Venous
Catheter Placement
www.youtube.com/watch?v=Ahz1SPKtiBU



Pressure ulcers

Pressure ulcers, which are often associated with poor care, fragile skin and suboptimal nutritional status, are a cause of great distress to patients and their families. They are common, difficult and expensive to treat, and are generally associated with poor health outcomes. The following resources link to articles written by physicians who offer their expertise to assist you in preventing and treating pressure ulcers.

JAMA

Reddy M, Gill SS, Rochon PA. Preventing pressure ulcers: a systematic review. *JAMA*. 2006;296(8):974–984. <http://jama.ama-assn.org/cgi/reprint/296/8/974>. Accessed January 27, 2008.

The authors of this *Journal of the American Medical Association (JAMA)* article conclude that using supportive surfaces, repositioning the patient, optimizing nutritional status and moisturizing sacral skin are appropriate strategies to prevent pressure ulcers. However, the authors state that, considering the methodological limitations of many of the randomized controlled trials they reviewed, there is a need for additional research on these non-pharmacological interventions.

JAMA Patient Page

Zeller JL, Lynn C, Glass RM. Pressure ulcers. *JAMA*. 2006;296:1020. <http://jama.ama-assn.org/cgi/content/full/296/8/1020>. Accessed January 28, 2008.

With simple illustrations and accompanying text, this patient resource explains pressure ulcer locations, stages and prevention. You can use this resource when discussing pressure ulcers with your patients and their families.

eMedicine from WebMD

Salcido R, Popescu A. Pressure ulcers and wound care. *eMedicine from WebMD*. www.emedicine.com/pmr/topic179.htm#top. Updated: August 10, 2006. Accessed January 28, 2008.

The author and co-author present a comprehensive but concise tutorial on pressure ulcers and wound care. Included in their work are references to additional professional resources.

Additional resources

David Hutchens

Emerging Principles of Complexity
www.davidhutchens.com/Biz%20Writing/articles/emergingprincipl.html

An organizational change expert, Mr. Hutchens offers insight into complex systems, including health care systems.