

## Multi-Disciplinary RSI Reduction — New AORN Recommended Practices

Surgical-safety events usually are caused by problems with the way we do things (practices) and how we share knowledge and information about what we want to do (communication). No surprise that this is true for retained surgical items (RSIs).<sup>1</sup> To date, surgical sponges have been the most common RSI<sup>2</sup> and we have the most information about these types of cases.

If we study experiential evidence (root-cause analyses, focused reviews and event reports), we find that in approximately 80 percent of operating room (OR) cases when a retained surgical sponge was discovered hours, days, weeks, months or years later, the surgical team recorded the sponge count as correct at the end of the operation. (This excludes cases of retained vaginal sponges after a spontaneous vaginal birth, cases where sponges were intentionally left in for therapeutic packing or cases where the patient was too sick to continue an operation.) This is referred to as *correct count retention cases* (CCRCs) even though the after-event analysis revealed that the “correct” count was wrong. In 20 percent of cases where a retained surgical sponge was reported, the final count was recorded as incorrect. That is, at the end of the operation the surgical team knew they were missing a sponge, yet the patient still left the OR with the sponge inside his/her body. This is referred to as *incorrect count retention cases* (ICRCs).

Even though the end result in both types of cases is a retained sponge, the causes of retention are different. In CCRCs, the primary problem is usually with OR practices related to the way in which the

sponges are accounted (or not), while in ICRCs, the team knows there is a missing surgical item (MSI), but there are usually problems with communication. The surgeons, anesthesiologists, nurses and surgical technologists all have practice problems in CCRCs, and the surgeons, nurses, surgical technologists, radiologists and radiology technologists have knowledge and information problems in ICRCs. It may be that there are also some practice problems in ICRCs, but communication failures predominate, and similarly there are probably communication failures in CCRCs, but problems with OR practices of sponge removal and counting predominate. So, to prevent RSIs, practice change, knowledge and shared information between multi-disciplinary perioperative personnel are required.<sup>3</sup>

In July 2010, the Association of periOperative Registered Nurses (AORN), the recognized leading organization of OR nurses, published a new version of one of its Recommended Practices (RPs).<sup>4</sup> RPs are guidelines that have historically formed the foundation upon which all hospitals with ORs and procedural areas base their policies. The former RP, titled “Counts,” has been renamed “Prevention of Retained Surgical Items” and covers safety thinking, environmental control issues and new considerations for miscellaneous items and device fragments, and adjunct sponge management technology. Most importantly, AORN recognizes that a multi-disciplinary approach to prevention of RSIs is required. AORN received input from the American College of Surgeons and the American Association of Anesthesiologists, and has generated an excellent, far-reaching

and comprehensive set of team management guidelines to help hospitals. The RP includes actions that should be incorporated into hospital OR policies, for nurses, surgical technologists, surgeons, anesthesiologists, radiologists, radiology technologists and risk managers. Hospitals will have to move beyond “count policies” and toward the development of multi-stakeholder OR policies for the prevention of RSIs.

For a copy of the RP, go to [www.aorn.org/psrp](http://www.aorn.org/psrp). After reading it, continue to engage hospital staff and medical staff who **must work together** to ensure patients leave the OR with “NoThing Left Behind.”

— Verna C. Gibbs MD, [NoThing Left Behind](http://NoThingLeftBehind.org)®, [drgibbs@nothingleftbehind.org](mailto:drgibbs@nothingleftbehind.org)

### References:

1. Gibbs VC. Patient safety practices in the operating room: correct-site surgery and nothing left behind. *Surg Clin North Am.* 2005;85:1307.
2. Cima RR, Kollengode A, Garnatz J, Storsveen A, Weisbord C et al. Incidence and characteristics of potential and actual retained foreign object events in surgical patients. *J Am Coll Surg.* 2008;207;80.
3. Gibbs VC, Coakley RD, Reines HD. Preventable errors in the operating room: retained foreign bodies after surgery — part 1. *Curr Probl Surg.* 2007;44:281.
4. AORN, Perioperative Standards and Recommended Practices, July 2010, online at: [www.aorn.org/psrp](http://www.aorn.org/psrp).

## Peer Review Study Released

The final results of the 2009 American College of Physician Executives' Peer Review Outcomes Study, just released online by the *American Journal of Medical Quality*, show that when doctors do clinical peer review using new methods, hospitalized patients benefit from safer care.<sup>1</sup>

They also show that few are using these methods. It seems to be a problem of inertia. Although the required changes are both desirable and relatively easy, physicians are struggling against a 30-year legacy of dysfunctional practice. There is great value in dealing with this. The potential impact can be compared to the IHI 100,000 Lives campaign.

In the new model, physicians evaluate each other's performance using the same Quality Improvement (QI) principles that have served well elsewhere in medicine and in other fields. You know that medical care is complex. It requires coordination of many professional disciplines and lots of information. This system of care is itself the source of many errors. The (QI) Model recognizes this. When clinical peer review focuses on learning from mistakes instead of casting blame, problems get fixed.

There are resources in the public domain to assist you and other leaders with program changes including a self-evaluation tool available at [QAtoQI.com/set.htm](http://QAtoQI.com/set.htm). A second article published in the November/December issue of the *American Journal of Medical Quality* attests to the validity of this tool and offers practical recommendations for improvement.<sup>2</sup>

The old QA method of clinical peer review is a narrow extension of the activity that hospitals are required to perform

to assure they have a competent medical staff. It focuses only on the physician and ignores the system. It is perceived as threatening. Doctors don't become incompetent overnight unless they have a major health event like a stroke that is obvious to everyone. Good physicians can have bad outcomes, often from circumstances beyond their immediate control. It's not helpful to cast blame.

— Marc Edwards, MD MBA [QA to QI Consulting](http://QAtoQI.com), [marc@QAtoQI.com](mailto:marc@QAtoQI.com)

## References

1. Edwards MT. The Objective Impact of Clinical Peer Review on Hospital Quality and Safety. *American journal of medical quality*. 2010.
2. Edwards MT. Clinical peer review program self-evaluation for US hospitals. *American journal of medical quality*. 25(6):474-80.

## Error Identifying Anesthetic Agent

This report details an error by an inexperienced pharmacist committed when handling easily confused medications with similar drug names. One patient's death at this major teaching hospital was ascribed to the inadvertent drug swap. The event shook the self-confidence of those at the institution and was broadly covered in the popular press.

## Case report

"The occurrence in this Hospital a few days since of two unfortunate cases, one of which proved fatal, renders it desirable that an explanation should be made of their course and cause. I shall attempt this explanation the more readily, as it will afford a great practical lesson, which you may never again have an opportunity of witnessing.

"This hospital was founded about thirty years since. The most distinguished men of our community ... were among those who devoted their time, talents and property to the erection of the Institution, and who have continued to support it by their paternal care. These names are a pledge to the community that it has been conducted with all the wisdom human ingenuity could furnish.

"[We rarely change personnel. When hiring a new chief pharmacist,] a considerable time is required for the new incumbent to acquaint himself with the customs and practices of the Institution; and it is obvious that such a change, involving an immense number of details, cannot occur without some oversights and mistakes. No mistakes, however, of any importance have come to our knowledge previous to those connected with the late accidents.

"A number of operations were to be performed, and the patients to be etherized. For this etherization, Chloric or Sulphuric Ether is usually employed. Chloroform, the popular favorite, is never used in this institution, except as an external application; but on this occasion it was introduced from the fact that it had been poured into a bottle labelled with

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the title ‘Concentrated Chloric Ether.’ This bottle, then, marked as concentrated chloric ether, was placed on the table, and employed for these operations without suspicion on our part that it was not the article designated by the label on its surface. The error escaped the observation of those who administered it, from the fact that there is a resemblance in the sensible qualities of the two articles. So that three persons were etherized with chloroform instead of chloric ether.”

(The report then discusses three consecutive operations. The first was uneventful, the second patient had an intraoperative cardiac event but was successfully resuscitated, and the third patient arrested at the end of the case, was successfully resuscitated, but died from a cardiac arrest later that day.)

“Immediately after the occurrence of alarming symptoms in [the third] case, it was discovered that the substance which had been used was not chloric ether, but chloroform; and not till then did we understand the extraordinary phenomena which presented themselves in this and the preceding case. This patient died with the usual phenomena of chloroform poison.”

## Comment

General anesthetics that are liquid at room temperature are easily mistaken for each other. While at that time chloroform was a popular anesthetic elsewhere, this surgeon, alarmed by scattered reports of sudden death associated with chloroform anesthesia, had banned its use as an anesthetic agent in his hospital. It was, however, still used for external application. Thus it was stocked in the pharmacy. This, along with the recent employment of a new pharmacist who was not familiar the surgeon’s concerns, provided a situation in which human error was likely to

occur. “Chloric ether” and “chloroform” are similar names; another potentially contributing factor.

Several advances since have reduced this risk. Chloroform is no longer used as an anesthetic: it is now known to induce fatal cardiac arrhythmias. Anesthetic bottles now have safety interlocks, preventing such swaps.

But humans are as susceptible to error as then and always will be. Many drugs have similar names and containers. New employees are starting at facilities all the time. Emerging risks may not be known to everyone without good communication. And early indications that something is wrong may be overlooked.

Human error is an intrinsic component of health care. We cannot regulate it out of existence, create policies banning it, or eliminate it through training. We can, however, reduce both the incidence of errors and the consequences of those that do occur through training (e.g., simulation, team work, mindfulness), adoption of a culture of safety and improvements in products, procedures, systems and work environment.

— Rory Jaffe, MD MBA [rjaffe@calhospital.org](mailto:rjaffe@calhospital.org)

## Reference

Warren JC. Remarks of Dr. J. C. Warren to the medical class and other gentlemen on a death by chloroform, accidentally administered in the Massachusetts General Hospital. *New England journal of medicine*. 1852;47:353-361.

## Illegibility

### *Meaningful communication*

As of late, I’ve heard the buzzword “meaningful use” thrown around liberally when it comes to discussions about electronic health records. The whole point of medical records is to document patients’ care and have all the pertinent information in one place for the multidisciplinary teams to review.

When you look at the root causes of sentinel events, adverse events or just health care incidents in general, the most common theme in terms of contributing factors is communication. Hospitals look at points of communication such as hand offs and reporting, but I don’t hear much about the issues around legibility in health care records. The fact is that medical records — whether paper or electronic — should be a focus when it comes to identifying root causes of patient-safety incidents.

### *Implications of illegible documentation*

The Institute for Healthcare Improvement’s trigger tool methodology focuses on specific documentation elements to identify events such as adverse drug reactions. Why don’t we think of trigger tools as they apply to issues that affect patient safety? If a nurse cannot read a medication error, he/she spends time calling the provider to clarify. Or better yet, he/she scans the illegible order to pharmacy and the pharmacist is then interrupted to call to clarify. Look at the time and resources wasted!

In addition to the difficulties that staff encounter while clarifying illegible documentation, there are also implications for the patient. First of all, there is a delay in treatment because the medication cannot be dispensed until the order is clarified.

Also, if the order is not clarified, there is the potential for a medication error to occur.

## Addressing impediments to communication

Recall when The Joint Commission established the “do not use” abbreviations list. I heard countless complaints from health care workers about having to comply with these standards. The general feeling was that The Joint Commission was trying to make things difficult by changing the rules. But it was only asking hospitals to fix apparent communication problems affecting patient safety.

The sentinel events that are reported provide The Joint Commission with the following year’s areas of focus and the basis for developing the National Patient Safety Goals. The Joint Commission doesn’t just come up with these requirements out of thin air. Illegible handwriting — a big impediment to effective communication — does need to be addressed.

## Bad handwriting = negligence!

Recent readings (see reference) warn that providers who have been notified about improving their handwriting, and still do not, can be sued for “negligence.” It can be negligent to not do something so simple and relatively effortless to prevent errors that result from miscommunication in medical records. Not correcting the problem (illegibility) can be viewed as recklessness.

In my opinion, the bottom line is why write anything in the medical record if nobody will understand what it means? Take a closer look at how medical records are being used as a communication tool in your hospital. This is where “meaningful use” comes in!

— Nicola Heslip, [Policy Medical™](#), [nicola@policymedical.com](mailto:nicola@policymedical.com)

## Reference

Glabman, M. [Death by handwriting](#). *Trustee*. 2005.

## Reducing Errors in Electronic Prescriptions

A new regulation effective January 2011, *Patient-Centered Labels for Prescription Drug Containers (Title 16 Section 1707.5)*, includes among other provisions a standardized set of patient instructions expected to cover about 90 percent of prescriptions. While the regulation affects labels on drug containers dispensed to patients, the standardized text can also provide a method for reducing discrepancies on other documents such as discharge instructions and prescription slips.

In [last month’s CHPSO Patient Safety News](#) we noted that discrepancies between structured and free-text fields in electronic prescriptions are common and can cause patient harm. Standardized instruction text can reduce that risk if an electronic health record is able to generate the free-text instructions field from the structured data.

The standard phrases are (IADF stands for ‘insert appropriate dosage form’):

- Take 1 IADF at bedtime
- Take 2 IADF at bedtime
- Take 3 IADF at bedtime
- Take 1 IADF in the morning
- Take 2 IADF in the morning
- Take 3 IADF in the morning

- Take 1 IADF in the morning, and Take 1 IADF at bedtime
- Take 2 IADF in the morning, and Take 2 IADF at bedtime
- Take 3 IADF in the morning, and Take 3 IADF at bedtime
- Take 1 IADF in the morning, 1 IADF at noon, and 1 IADF in the evening
- Take 2 IADF in the morning, 2 IADF at noon, and 2 IADF in the evening
- Take 3 IADF in the morning, 3 IADF at noon, and 3 IADF in the evening
- Take 1 IADF in the morning, 1 IADF at noon, 1 IADF in the evening, and 1 IADF at bedtime
- Take 2 IADF in the morning, 2 IADF at noon, 2 IADF in the evening, and 2 IADF at bedtime
- Take 3 IADF in the morning, 3 IADF at noon, 3 IADF in the evening, and 3 IADF at bedtime
- If you have pain, take \_\_\_ IADF at a time. Wait at least \_\_\_ hours before taking again. Do not take more than \_\_\_ IADF in one day

For example, if pills are dispensed and the physician wrote “*sig: i po qhs*,” the instructions would read “Take 1 pill at bedtime.”

Note that, even when the instruction specified by regulation basically fits the prescription as issued by the prescriber, it is appropriate to include additional information (such as time increments between doses) on the prescription label, if it is necessary for the safety of the patient.

— Rory Jaffe, MD MBA [rjaffe@calhospital.org](mailto:rjaffe@calhospital.org)

## Teleconferences

In addition to our regularly-scheduled Just Culture support calls, CHPSO will be holding three special teleconferences in February.

### *Template hospital policy and procedure*

February 7, 10 AM. Template hospital policy and procedure for working with Patient Safety Work Product and a PSO. The call is open to CHPSO members and others intending to sign with CHPSO in the next few months.

We will be discussing how to effectively integrate the PSO protections and reporting into your current processes, expand communication within your organization as well as between organizations, and maintain the ability to discharge your legal commitments such as peer review and external reporting.

We will also distribute a template policy that can be adapted to your needs.

Speakers: Rory Jaffe, MD MBA, Executive Director, CHPSO and Ann O'Connell, Partner, Nossaman LLP.

### *Retained Surgical Items*

February 16, 3 PM. Retained Surgical Items. This call is open to CHPSO members only.

We will discuss causes of Retained Surgical Items (RSIs) and the variety of approaches that can be taken to reduce their incidence. We will also discuss how one organization rolled out a comprehensive program to reduce RSIs.

Speakers: Verna Gibbs, MD, NoThing Left Behind® and Barbara Pelletreau, RN MPH, VP Patient Safety & Clinical Risk Management, Catholic Healthcare West.

### *Just Culture for HR leaders*

February 18, 10 AM. Just Culture for HR leaders. This call is open to all.

This interactive session, featuring two HR leaders in organizations that have made significant progress in adopting a just culture, will help you understand why HR is an important leader in adopting this culture change, the pitfalls of just culture, as well as the benefits that just culture implementation bring to HR processes.

Speakers: Steve Eckberg, SPHR CCP, Vice President, Human Resources, St. Mary Medical Center (Apple Valley) and Joanne Webster, SPHR CA, Director, Human Resources, Community Hospital of the Monterey Peninsula.

### *Registration*

To register, contact La Shon Tate at [ltate@calhospital.org](mailto:ltate@calhospital.org). Specify which call(s) you are registering for, and include your name, position and organization. There is no charge for these calls.

As a reminder, eligibility for these calls is as follows:

- Template hospital policy: CHPSO members and others intending to sign with CHPSO in the next few months.
- Retained surgical items: CHPSO members.
- Just Culture for HR leaders: open to all.

— Rory Jaffe, MD MBA [rjaffe@calhospital.org](mailto:rjaffe@calhospital.org)

## Participant Recognition Program

CHPSO is developing means to properly recognize those hospitals that are participating in the patient safety organization and their commitment to making health care safer. Beginning in February, participating hospitals will be listed on the CHPSO website and materials will be developed to assist hospitals in their own promotional campaigns.

## Safer Surgery Guide

The UK National Health Service just released a [‘How to Guide’ for safer surgery and the WHO surgical checklist](#). The guide includes helpful advice to improve teamwork and communication as well as implementation of the checklist. As stated in the guide:

“Teamwork does not emerge naturally. It is necessary to provide time, facilities and support to help individual staff to become a good team. A few simple team building opportunities included in daily work can reduce cost and improve the quality of care.”

The guide is a useful overview for those implementing the checklist, and:

perioperative teams,

governance teams,

relevant service managers,

senior managers and/or executive leads supporting the work and monitoring its progress, and

service improvement staff who are required to provide improvement or change management expertise in relation to surgery.

## Calendar

The following upcoming events are still open for enrollment. For more information or to enroll, use the contacts listed below.

### January

**10:** *CHPSO*: Just Culture Support Call. 10–11 AM.

**11:** *BEACON*: El Camino Site Visit — Magnet Survey. Mountain View.

**13:** *BEACON*: Compass Series 1 of 4. Oakland.

**18:** *SCPSC* (Southern California Patient Safety Collaborative): Third Annual Patient Safety Colloquium. Long Beach.

**21:** *PSCSD&IC* (Patient Safety Council of San Diego & Imperial Counties): Reduce Preventable Readmissions through Networking (PRN). San Diego.

**25:** *BEACON*: Quarterly Meeting. South San Francisco.

**28:** *SCPSC*: Perinatal Monthly Webinar. 12:15 PM.

### February

**3:** *BEACON*: Practical Skills for Quality Improvement. Castro Valley.

**7:** *CHPSO*: Policies and Procedures for Working With a PSO. Teleconference 10–11 AM.

**10:** *BEACON*: Compass Series 2 of 4. Oakland.

**14:** *CHPSO*: Just Culture Support Call. 10–11 AM.

**15:** *SCPSC*: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis

and Surgical Care Improvement Project. Industry Hills.

**16:** *CHPSO*: Retained Surgical Items. Teleconference 3–4 PM.

**16:** *PSCSD&IC*: HAI Elimination. San Diego.

**18:** *CHPSO*: Just Culture and HR. Teleconference 10–11 AM.

**22:** *SCPSC*: Perinatal Monthly Webinar. 12:15 PM.

**23:** *PSCSD&IC*: Ending Elective Deliveries Before 39 Weeks Gestation. TBD.

### March

**4:** *CAPSAC*: California Patient Safety Action Coalition meeting. Sacramento.

**9:** *PSCSD&IC*: Reduce Preventable Readmissions through Networking (PRN). San Diego.

**10:** *BEACON*: Compass Series 3 of 4. Fremont.

**14:** *CHPSO*: Just Culture Support Call. 10–11 AM.

**15:** *SCPSC*: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

**24:** *SCPSC*: Perinatal Monthly Webinar. 12:15 PM.

### April

**7:** *SCPSC*: Track III — Perinatal Care. Industry Hills.

**10:** *CHPSO*: Just Culture Support Call. 10–11 AM.

**14:** *BEACON*: Compass Series 4 of 4. Oakland.

**20:** *PSCSD&IC*: HAI Elimination. San Diego.

**25:** *BEACON*: Annual Exchange Pre-Conference. Burlingame.

**26:** *BEACON*: Annual Exchange. Burlingame.

### May

**9:** *CHPSO*: Just Culture Support Call. 10–11 AM.

**11:** *PSCSD&IC*: Reduce Preventable Readmissions through Networking (PRN). San Diego.

**24:** *SCPSC*: Perinatal Monthly Webinar. 12:15 PM.

**24:** *SCPSC*: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis and Surgical Care Improvement Project. Industry Hills.

**25:** *PSCSD&IC*: Ending Elective Deliveries Before 39 Weeks Gestation. TBD.

### June

**13:** *CHPSO*: Just Culture Support Call. 10–11 AM.

**15:** *PSCSD&IC*: HAI Elimination. San Diego.

**21:** *SCPSC*: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

**28:** *SCPSC*: Perinatal Monthly Webinar. 12:15 PM.

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## July

**11:** CHPSO: Just Culture Support Call.  
10–11 AM.

**13:** PSCSD&IC: Reduce Preventable Readmissions through Networking (PRN). San Diego.

**13:** SCPSC: Track III — Perinatal Care. Industry Hills.

## August

**8:** CHPSO: Just Culture Support Call.  
10–11 AM.

**9:** SCPSC: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis and Surgical Care Improvement Project. Industry Hills.

**17:** PSCSD&IC: HAI Elimination. San Diego.

**23:** SCPSC: Perinatal Monthly Webinar.  
12:15 PM.

**24:** PSCSD&IC: Ending Elective Deliveries Before 39 Weeks Gestation. TBD.

## September

**12:** CHPSO: Just Culture Support Call.  
10–11 AM.

**13:** SCPSC: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

**14:** PSCSD&IC: Reduce Preventable Readmissions through Networking (PRN). San Diego.

**27:** SCPSC: Perinatal Monthly Webinar.  
12:15 PM.

## October

**10:** CHPSO: Just Culture Support Call.  
10–11 AM.

**19:** PSCSD&IC: HAI Elimination. San Diego.

**25:** SCPSC: Perinatal Monthly Webinar.  
12:15 PM.

## November

**8:** SCPSC: Track I — Hospital Acquired Infections in the ICU Setting, Sepsis and Surgical Care Improvement Project. Industry Hills.

**9:** PSCSD&IC: Reduce Preventable Readmissions through Networking (PRN). San Diego.

**14:** CHPSO: Just Culture Support Call.  
10–11 AM.

**15:** SCPSC: Track III — Perinatal Care. Industry Hills.

**23:** PSCSD&IC: Ending Elective Deliveries Before 39 Weeks Gestation. TBD.

## December

**12:** CHPSO: Just Culture Support Call.  
10–11 AM.

**13:** SCPSC: Track II — Pressure Ulcers, Readmissions and Transitions of Care. Industry Hills.

**14:** PSCSD&IC: HAI Elimination. San Diego.

*For further information on these events:*

BEACON: Petrina Aiello [paiello@hospitalcouncil.net](mailto:paiello@hospitalcouncil.net) or [www.beaconcollaborative.org](http://www.beaconcollaborative.org)

CAPSAC: John Keats [John.Keats@CHW.edu](mailto:John.Keats@CHW.edu) or [www.capsac.org](http://www.capsac.org)

CHPSO: Rory Jaffe [rjaffe@calhospital.org](mailto:rjaffe@calhospital.org)

PSCSD&IC: Lindsey Wade [lwade@hasdic.org](mailto:lwade@hasdic.org)

SCPSC: Catherine Carson [ccarson@hasc.org](mailto:ccarson@hasc.org)

## Instructions to Authors

Prospective authors may submit articles to Rory Jaffe, MD, MBA ([rjaffe@calhospital.org](mailto:rjaffe@calhospital.org), 916.552.7568). Typical articles will be brief — between 200 and 600 words. Additional information may be provided as web links. If accepted, the additional information may be hosted on the CHPSO website. A completed [publication agreement form](#) must be submitted prior to publication.

## About This Newsletter

CHPSO Patient Safety News provides lessons learned from reviews of patient safety events and news of patient-safety activities in this state. We hope you will find it useful in your efforts to improve patient outcomes. This newsletter may be freely distributed in its original form. Copies of each newsletter are archived on the CHPSO website ([www.chpso.org](http://www.chpso.org)).

— Rory Jaffe, MD MBA [rjaffe@calhospital.org](mailto:rjaffe@calhospital.org)