CHILD HEALTH PATIENT SAFETY ORGANIZATION

Serious Safety Event Action Alert

July 2015

A Patient Experienced a SERIOUS SAFETY EVENT

Take Action to Reduce Risk of Similar Harm

Event: Recognition of Retained Foreign Body - Button Battery

Target Audiences

Quality, Patient Safety, Legal/Risk Management, Cause Analysis Staff, Organizational Leaders, Radiology, Speech Pathology, ENT Services, Gastroenterology Services, Respiratory Therapy, After Hours Nursing Triage, Primary Care, Emergency/Urgent Care

Resultant Harm to the Patient

A patient required surgery for removal of a retained button battery, which required subsequent surgeries to repair esophageal damage.

Fundamental Issue

Ingested button batteries remain conductive and can cause tissue erosion and significant damage if not removed in a timely manner. A deviation in practice resulted in a failure to recognize a retained button battery in a patient's esophagus. Providers did not consider ingestion of a foreign object as a possible cause of the patient's acute dysphagia with solid foods. There was a lack of communication among the providers, and, even though patient care information was available to providers, critical concerns were neither highlighted nor prioritized. Closed-loop communication was not used to verify receipt of the results of the swallowing evaluation and the pathologist's concerns by the provider.

Actions to Mitigate Risk of Similar Harm at Your Hospital

- Order a low dose radiation "scout" film prior to a patient receiving barium for a swallow study.
- Develop practice guidelines/pathway that prompts providers to consider a foreign body as the cause for acute dysphagia for GI, Radiology, Respiratory Therapy, General Pediatrics/Hospitalist, Surgery, and Speech Pathology.
- Develop a clear definition of "critical result" (e.g., swallowing evaluation) and process of reporting critical results from all ancillary tests to providers in your EMR.
- Include "foreign body," especially including button batteries, in the EMR Well Child Checklist for young patients (under 5) and during well-child visits in the ambulatory setting.
- Raise public awareness through the dissemination of information about harm related to the ingestion of a button battery.
- Develop standard work instructions and a clear process for consulting providers to escalate patient care concerns, recommendations, and any critical results to the primary care provider.

Additional Resources

- http://www.poison.org/battery/guideline.asp
- http://www.hindawi.com/journals/bmri/2013/846091
- http://www.chop.edu/centers-programs/kohls-injury-prevention-program/lithium-button-batteries#.VY1_-k3bLcs
- http://thebatterycontrolled.com/the-facts/
- http://www.safekids.org/safetytips/field_audience/safety-professionals/field_risks/batteries

Has a patient experienced an event at your organization that could happen in another hospital?

- *Child Health PSO members should submit event details into the Child Health PSO portal.*
- *Contact Child Health PSO Staff to share risks, issues to assess, and mitigation strategies with member hospitals.*
- *More than 50 children's hospitals are actively engaged with Child Health PSO. We currently are enrolling new members.*

What can I do with this Alert?

- Forward this Alert to the recommended target audience for evaluation.
- Include in your Daily Safety Brief.
- Create loop-closing process for evaluating risks and strategies implemented to decrease risk of repeat harm.
- Let Child Health PSO know what is working and what additional information you need.

Leverage your PSO membership: *Learn from each other to reduce patient harm and Serious Safety Events*

Contact Us

psosupport@childpso.org

This Alert is approved for general distribution to improve pediatric safety and reduce patient harm. This Alert meets the standards of non-identification in accordance with 3.212 of the Patient Safety Quality Improvement Act (PSQIA) and is a permissible disclosure by Child Health PSO.

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