

# CHILD HEALTH PATIENT SAFETY ORGANIZATION

## Serious Safety Event Action Alert

February 2017



## SERIOUS SAFETY EVENTS

Take Action to Reduce Risk of Similar Harm

### Event: Thermal Injuries

#### Target Audiences

Nursing, Medical, Clinical and Surgical Leaders, Quality Improvement, Patient Safety, Legal/Risk Management, Clinical Educators, Organizational Leaders, Primary Care, Emergency/Urgent Care, Supply Chain Services, Home Care, Ambulatory Care

#### Resultant Harm

Thermal devices (hot or cold) can cause thermal injuries (e.g., severe burns, pressure ulcers, blisters, scarring and wounds) in pediatric patients when products are not available and result in the use of an improvised device or when approved devices are used inappropriately. Injuries from thermal products/devices can result in the need for additional treatment (e.g., wound care, antibiotic therapy, surgical intervention).

#### Fundamental Issue

Thermal devices are used in various clinical settings and can cause serious harm (e.g., severe burns, pressure ulcers, scarring) to pediatric patients. For example, patient harm can occur when clinicians:

- Lack knowledge or understanding in the selection of the appropriate population-appropriate devices/products and overlook patient-specific risks that can affect the intended therapeutic treatment.
- Lack awareness of manufacturer guidelines for appropriate use and monitoring recommendations especially in compromised patients (e.g., immobile, non-verbal, diminished sensory/physiology sensations).
  - “Over the counter” products can lead to a lack of appreciation of the potential harm by clinicians, patients and organizations.
- Misuse products used for patient care by manipulating products for pediatric use.
- Utilize products for unintended uses (e.g., use of a penlight to illuminate a vein for the insertion of an intravenous catheter, which resulted in a burn).
- Create work-arounds when products are unavailable (e.g., warm compresses made with hot water from a coffee pot when heel warmers were out of stock).

#### Recommendations to Mitigate Thermal Injuries at Your Hospital

- Contact manufacturers of thermal devices used in your institution for practice recommendations and standardize training for all clinicians when new or updated product becomes available.
- Conduct a risk assessment to determine organizational gaps related to thermal injuries.
  - Use the provided [Risk Assessment Tool](#) developed by a team of your peers from children's hospital across the country.

#### ***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](mailto: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.*