CHILD HEALTH PATIENT SAFETY ORGANIZATION

Serious Safety Event Action Alert

March 2014

A Patient Experienced a SERIOUS SAFETY EVENT

Take Action to Reduce Risk of Similar Harm

Event: Wrong-Size Tracheostomy Selection

Target Audiences

Quality, Patient Safety, Legal, Risk Management, Cause Analysis Staff, Organizational Leaders, Perioperative and Otolaryngology Clinical Leaders

Resultant Harm to the Patient

A patient required increased oxygen, ventilator support, sedation and paralytics when the wrong-size cuffed tracheostomy tube was inserted. Upon recognition that the size of the cuffed tube (inner diameter) was not as intended, the tracheostomy tube was changed to what was ordered and appropriate for the patient.

Fundamental Issue

There are multiple numbers on the packaging of pediatric cuffed tracheostomy tubes. The tube selected was stocked incorrectly in the labeled supply cart. Care providers relied on other team members for the selection and verification of the correct tracheostomy tube. There was inadequate verification of the inner diameter of the tracheostomy tube size prior to insertion. The outer diameter size of the tracheostomy tube size was assumed to be the inner diameter intended.

Actions to Mitigate Risk of Similar Harm at Your Hospital

- Communicate and validate the tracheostomy tube specifics (brand, cuff, inner and outer diameter size) with all team members prior to all tracheostomy tube insertions.
- Communicate and validate the tracheostomy tube type (brand, cuff, inner and outer diameter size) during hand-offs.
- Review and validate supply cart stocking processes to ensure that all tracheostomy tubes are placed in their respective labeled locations. Audit carts daily for accuracy.
- Review prior wrong-size tracheostomy tube events in your organization. If events have brands in common, initiate processes to ensure clarity of product labeling. (The review at the reporting hospital found the same brand of cuffed tracheostomy tubes was involved. This was reported for product labeling concerns).

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

- *Child Health PSO members 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.*
- *Forty children's hospitals are actively engaged with Child Health PSO. We currently are enrolling new members.*

Children's Hospitals' Solutions for Patient Safety
Every patient. Every day.

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

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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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