

CHILD HEALTH PATIENT SAFETY ORGANIZATION

Serious Safety Event Action Alert

July 2016



SERIOUS SAFETY EVENT

Take Action to Reduce Risk of Similar Harm

Event: Silicone-Foley Catheter Balloon Rupture

Target Audiences

Nursing, Medical and Clinical Leaders, Quality Improvement, Patient Safety, Legal/Risk Management, Clinical Educators, Organizational Leaders, Urology Services, Primary Care, Emergency/Urgent Care

Resultant Harm

Foley balloon rupture can lead to a urinary tract infection and/or sepsis requiring antibiotic therapy. Resultant harm may also include the need for surgical intervention for the removal of any retained catheter fragments.

Fundamental Issue

Foley catheters inserted incorrectly can cause significant tissue damage leading to infection (including sepsis) and the need for surgical intervention. Deflation of silicone catheter balloons can create ridges in the catheter balloon. These ridges make the catheter difficult to remove. To prevent this from occurring, manufacturers of silicone catheters may recommend eliminating the common practice of inflating and deflating a silicone urinary catheter balloon prior to insertion and use passive deflation (allowing the balloon to empty without drawing back the plunger) upon catheter removal. Both are differences in practice compared to latex urinary catheters. Lack of awareness around the practice with silicone catheters, and unclear practice guidelines can lead to significant harm to patients. Developing standard practices, job aides and real-time reminders related to insertion of silicone catheters is suggested. In addition, staff should be educated on the management and care of Foley catheters and the processes to follow in escalating Foley concerns.

Action Mitigate Risk of Similar Harm at Your Hospital

- Do not test the Foley balloon by inflation and deflation of Silicone catheters prior to insertion.
- Develop a clear set of practice guidelines that directs providers to refrain from testing the Foley balloon prior to insertion of silicone catheters.
- Raise awareness through the dissemination of information describing the elimination of silicone Foley catheter balloon inflation and deflation as a means to test catheters prior to insertion.
- Develop standard work instructions and a clear process for consulting providers to escalate Foley care concerns, recommendations, and any management concerns to the primary care provider.

Additional Resources

- Contact the manufacturer for the silicone Foley catheter used by your institution for practice recommendations.

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

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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 3.2.12 of the Patient Safety Quality Improvement Act (PSQIA) and is a permissible disclosure by Child Health PSO.