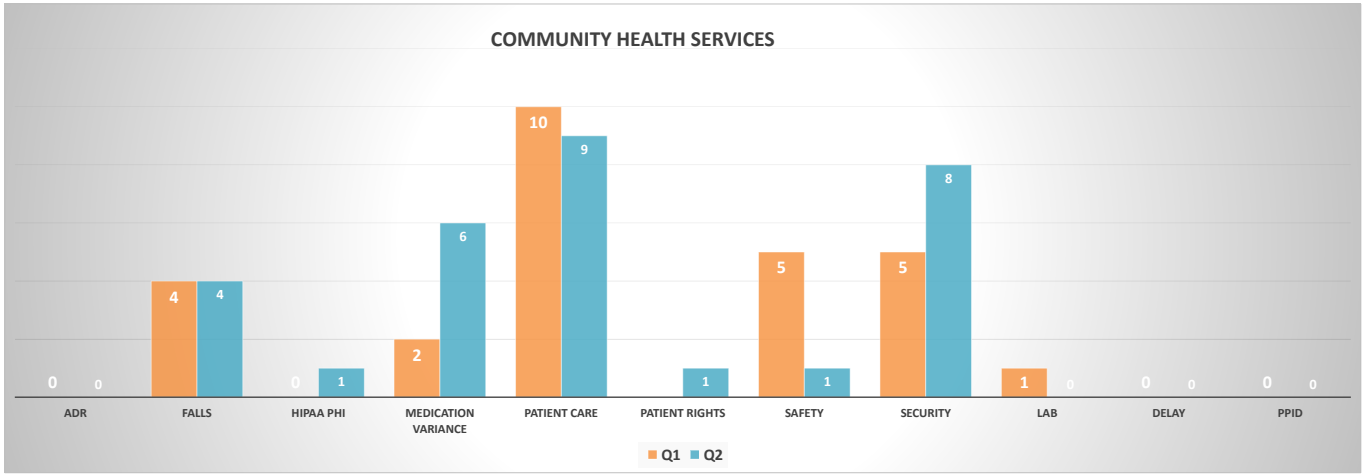
BROWARD HEALTH AMBULATORY SERVICES - RISK MANAGEMENT QUARTERLY REPORT QUARTER 2

COMMUNITY HEALTH SERVICES	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	Total CY19
ADR				0				0	0
Falls	2		2	4	2	1	1	4	8
HIPAA PHI				0	1			1	1
Medication Variance	2			2	4		2	6	8
Patient Care	4	4	2	10	3	1	5	9	19
Patient Rights				0	1			1	1
Safety	1	3	1	5			1	1	6
Security	2	2	1	5	2		6	8	13
Lab		1		1				0	1
Delay				0				0	0
PPID				0				0	0
Totals	11	10	6	27	13	2	15	30	57



Total of 30 occurrences reported.

Four Falls. One patient started falling asleep and fell from chair. One visitor fell from chair. Inspection of the chair showed seat separated from the cross bar, only 1 screw was found. All chairs were inspected and those with any faults removed for repairs. Patient seen at UCC, diagnosis of contusion. First notice of event completed. LOR received. Chair preserved as evidence. One visitor found on the floor at parking lot due to clinical event, transferred to hospital. One patient fell due to dizziness, no injuries.

HIPAA occurrence related to patient discharged from BHMC with wrong patient prescriptions. Pharmacy called BHMC and corrections made for both patients.

Six medication variances. One related to wrong drug. Valsartan interchanged with Losartan instead of Telmisartan ac cording to dose and CHS formulary, resulting in duplicate therapy. Pharmacist noted duplication in chart and contacted the patient who denied symptoms, still hypertensive, instructed on correct med and to schedule physician appointmen t. Patient was seen by PCP. Tech re-educated on importance of utilizing ambulatory formulary as reference. The RPh responsible for verifying the script was reminded of the importance of not only knowing therapeutic equiva lent drugs for substitution in our Pharmacy, but also of the importance of not bypassing alerts (which occurred in this circumstance). The pharmacy team now agrees that regularly therapeutic substituted drugs should be posted at each pharmacy workstation for visibility and easy access. One wrong dose when PV1 and PV2 were performed by same pharmacist. Double checks reinforced. APRN prescribed controlled substance without DEA, medical director aware. One patient received medication with wrong directions on label but took it as instrucetd by provider. One patient took extra doses of medication per daughter's instructions. Pharmacy re -educated patient and daughter and assisted with pill box. All events discussed on pharmacy weekly huddles. No harm to patients.

Nine patient care reported. Three transfers to higher level of care. One due to seizure while in waiting room. Documented history of seizures in chart. Other d ue to hypoglycemia with history of DM, patient administered am Insulin but did not eat due to fasting labs scheduled. Need to hold Insulin if not eating discussed with patient. One event reported disruptive behavior with grievance reported by patient about physician attitude. One reported patient non-compliance with grievance reported by patient about physician attitude. Both shared with medical director. Three patients refused transfer to ED (AMAs). Tip of drill fell apart during dental procedure. No harm to patient. Equipment maintenance contractor inspection performed.

Patient rights related to 17 year old who permitted her mother to be present during examination.

Safety related to ceiling tiles. Facilities contacted.

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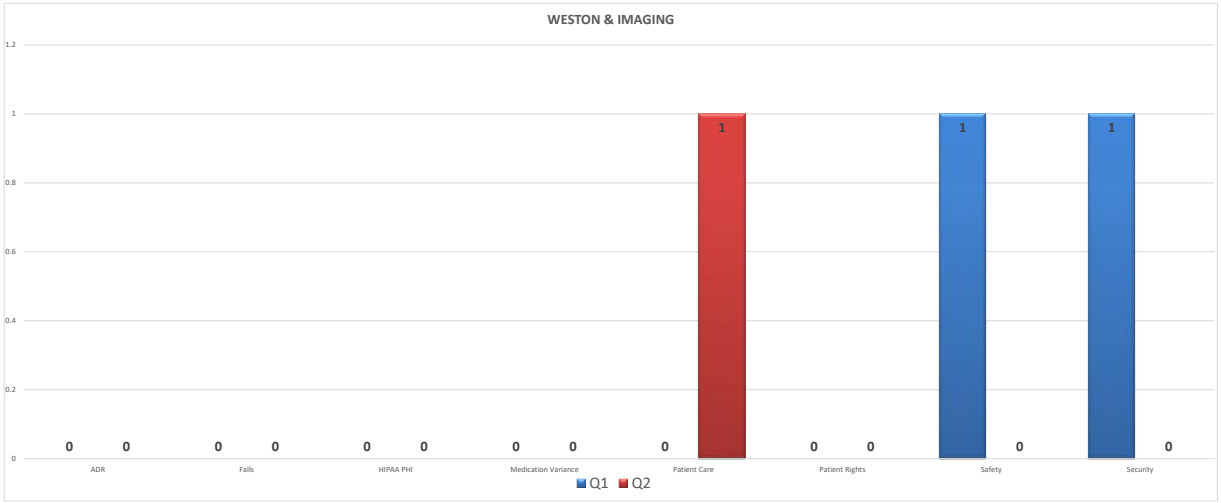
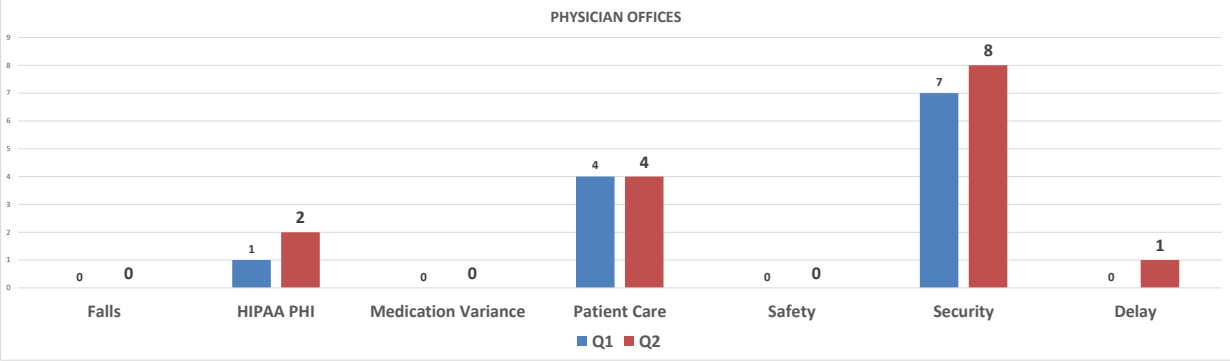
WESTON & IMAGING	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	Total CY19
ADR				0				0	0
Falls				0				0	0
HIPAA PHI				0				0	0
Medication Variance				0				0	0
Patient Care				0	1			1	1
Patient Rights				0				0	0
Safety			1	1				0	1
Security			1	1				0	1
Totals	0	0	2	2	1	0	0	1	3



Only one occurrence from imaging center.

Patient transferred to higher level of care due to near syncope after having MRI.

PHYSICIAN OFFICES	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	Total CY19
Falls				0				0	0
HIPAA PHI	1			1			2	2	3
Medication Variance				0				0	0
Patient Care	1	1	2	4	2	1	1	4	8
Safety				0				0	0
Security	1	4	2	7	2	3	3	8	15
Delay				0		1		1	1
Totals	3	5	4	12	4	5	6	15	27



Total of 15 occurrences.

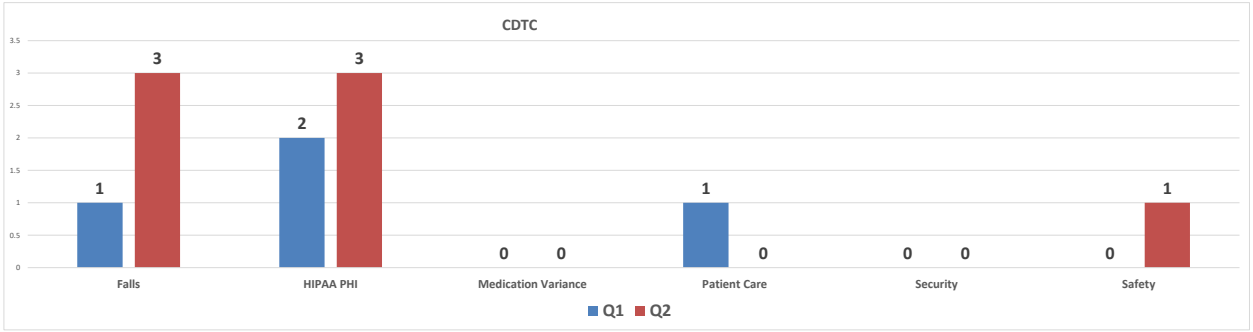
Two HIPAA occurrences due to charges entered under wrong patient. Appropriate corrections made. Investigated by compliance.

Four patient care events. One due to patient's disruptive behavior.
One patient requested copy of lab results after being placed on medication for hyperlipidemia during cardiology clearance. Of fice unable to find such results. Physician insisted he reviewed labs with patient during visit, showing paper results to patient and confirming her name and DOB. Patient disagreed, PCP never ordered lipid pa nel. Recommended lab draw. Shared with medical director.
Psychiatrist requested to terminate physician-patient relationship as patient was non-compliant, unstable, with several hospitalizations and refusing in-person appointment. Discussed with medical director. Referred to psychiatric clinic with more wrap-around services, including case management that could assist her with attending appointments.

Eight security events including 3 verbal abuses and 4 agressive behaviors. Decision to terminate physician -patient relationship with two patients due to safety concerns. Protocol for dealing with hostile patients reviewed with BHPG. Contributing factors leading to patients behaving belligerently/aggressively reviewed. Discusse d actions to be undertaken by staff when these situations occur, need for HAS reporting and criteria/process for terminating physician-patient relationship. Corporate Public Safety Office recently operation alized a centralized security operations and dispatch center which can be usefull for sites without security presence. Garnett will discuss option of having panic buttons at BHPG offices with leaders hip. Power point presentation prepared by the BHN Risk Management department shared with BHPG.
One related to office key lost, replaced.

One delay related to overnight answering service that could not be removed in the morning. Resolved.

CDTC	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	Total CY19
Falls			1	1	1	1	1	3	4
HIPAA PHI	2			2		3		3	5
Medication Variance				0				0	0
Patient Care		1		1				0	1
Security				0				0	0
Safety				0	1			1	1
Totals	2	1	1	4	2	4	1	7	11



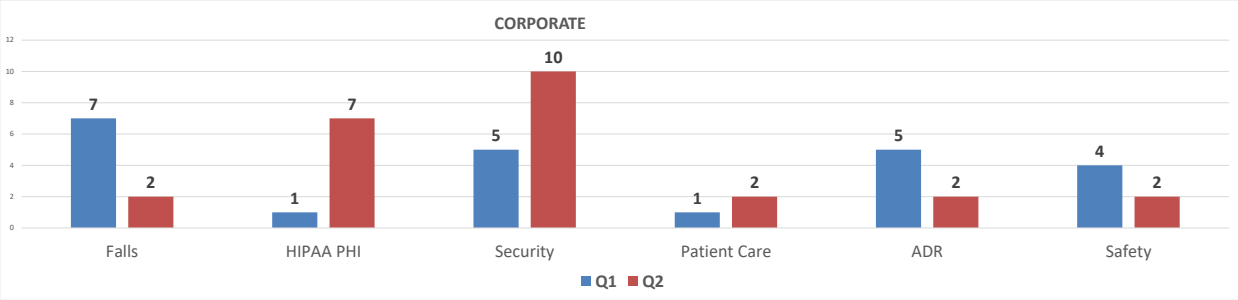
Total of 7 occurrences reported.

Two employee falls and one patient fall. No injuries or environmental factors which contributed to the occurrences.

Three HIPAA reports. Two emails sent to incorrect provider. One intake letter sent to correct address but with wrong mom's name. Investigated by compliance.

Safety event related to employee complaining of back pain, alleging it was related to pushing chart carts. Employee health notified. Contract with program used to get labels on charts recently renewed. Charts being stored in wheeled carts pending IT to install program before sending charts to medical records.

CORPORATE	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	Total CY19
Falls	2	2	3	7	1	1		2	9
HIPAA PHI	1			1	5	1	1	7	8
Security	1		4	5	3	1	6	10	15
Patient Care			1	1	2			2	3
ADR			5	5	2			2	12
Safety	1	2	1	4	2			2	6
				0				0	0
Totals	5	4	14	23	15	3	7	25	48



Total of 25 occurrences.

Two falls. One employee felt dizzy and was transferred to hopital. Another employee fell by elevator at ISC building, employee health notified, no injuries.

Seven HIPAA events. Compliance started using HAS to document their cases. One incorrect patient billed by BHMC. One report related to BHCS manager logged into a provider's account. Wrong itemized bill faxed to attorne's office. One attorney contacted complaince that billing records requested were not received. W ells Fargo notified BH that they learned on June 2, 2021, that on June 1, 2021, images intended for BH's online lockbox account were inadvertently posted to another customer's account due to a processing error. Wells Fargo confirmed that the ina dvertent recipient, also a "covered entity" under the Health Insurance Portability and Accountability Act (HIPAA), no longer has access to the information. One incorrect medical record emailed to vendor.

Three patient care events. One reporting suspicious patient behavior at vaccination site, leading to possible victim of abuse or human traffiic. This was noted by different caregivers at different areas of vaccination site. Site leader was able to speak with patient alone and when asked she stated all good at home. For abundance of caution, decision was to report findings to abuse hotline. One employee and one contracted vendor were transferred to ED due to clinical events.

Two ADRs from Lockheart Stadium vaccination site.

Two safety related. One needle stick at vaccination site, nurse sent to ED and employee health notified. One accident with employee without injuries.

Ten security reports. One treat of violence recived over the phone by PBO and reported days after. Meeting with all PBO st aff to review steps to be followed on similar situations and HAS reporting. One car parked for days at Spectrum, police notified. Others related to 1800 and 1700 Spectrum doors unlocked/open. Faciliti es fixed one and ordered equipment for the other door mechanism.