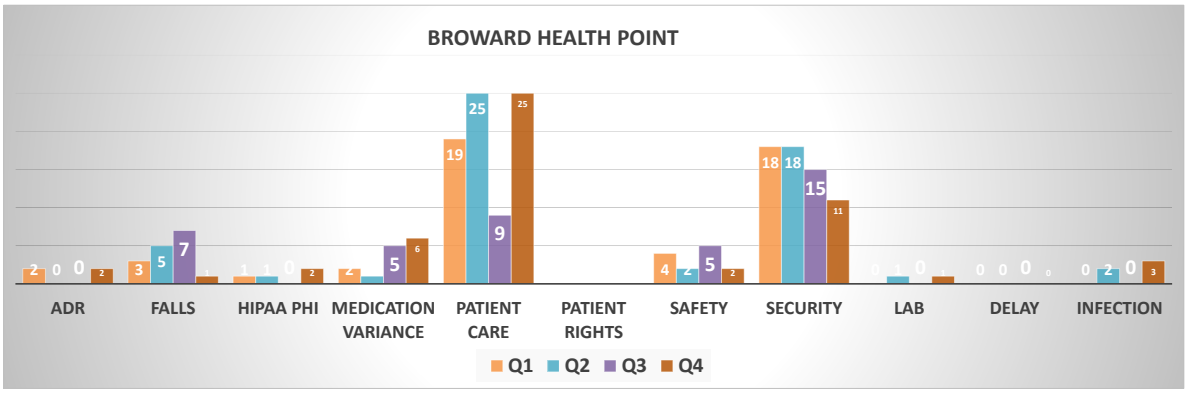
BROWARD HEALTH AMBULATORY SERVICES - RISK MANAGEMENT QUARTERLY REPORT QUARTER 4

BROWARD HEALTH POINT	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Oct	Nov	Dec	4th Qtr	Total CY22
ADR		1	1	2				0				0	2			2	4
Falls	2		1	3	1	2	2	5	4	2	1	7	1			1	16
HIPAA PHI		1		1	1			1				0	1		1	2	4
Medication Variance		1	1	2			1	1	2	3		5	4	2		6	14
Patient Care	4	9	6	19	9	11	5	25	2	3	4	9	12	10	3	25	78
Patient Rights				0				0				0				0	0
Safety	4			4		1	1	2	2	2	1	5	1		1	2	13
Security	6	6	6	18	5	5	8	18	3	9	3	15	4	4	3	11	62
Lab				0			1	1				0			1	1	2
Delay	0			0				0				0				0	0
Infection	0			0	1		1	2				0	2	1		3	5
Totals	13	0	0	49	17	19	19	55	13	19	9	41	27	17	9	53	162



Total of **50 occurrences** reported.

Twenty-five patient care events. Sixteen transfers to hospital due to medical conditions. Three patient disruptive behaviors. Failure in team communication regarding not being able to relate critical results to patient, meeting regarding team communication, patient's right to treatment refusal if not vulnerable, physician responsibilities during BA process. Pediatrician refused to see patient after SW assessment, reported to medical director, meeting with physician and team, leadership intends to replace this physician due to repeated events. Employee hurt while moving an exam table. Physician left office early due to patients on schedule, misunderstanding addressed by leadership. One physician documentation issue related to change in insulin order, re-educated.

Six medication variances. Tech delivered wrong bag to Quality Transportation service, patient noted wrong meds delivered, all prescriptions given to the courier will be run through the point of sale as it will alert the technician in the event of scanning the wrong patient prescription bag. Expired Jynneos (monkeypox vaccine) administered to patient who returned for another dose without side effects, pharmacy re-educated MA. Physician sent med order to pharmacy with wrong strength, wrong product/drug, wrong route and wrong duration, reviewed with physician and perinatology group. Wrong vaccines ordered by mistake and administered by MA, senior MA noted error, physician disclosed it to patient's mother who monitored patient for fevers and risk of seizures, patient medicated with Tylenol and no seizures observed, decision to move MA to prenatal and binder put in place with recommended childhood vaccine schedules as reference. Quality transportation service delivered med bag to wrong patient, compliance spoke with Vice President of Business Development at Quality to discuss allegation and confirm corrective action. Patient noted insulin for another patient, pharmacy suspected system glitch and is investigating.

Two ADRs. Patient reported adverse effects from Insulin IR, changed to Insulin ER, reviewed by medical director. Patient reported bleeding in stool and upset stomach due to Xarelto, switched back to Warfarin and followed at anticoagulation clinic.

Two HIPAA. Wrong ID bracelet was given to patient's mom, nurse called the infant back for intake process and verified the name and DOB of the baby on her paper labels but did not verify the bracelet on the infant. These are investigated by compliance/privacy team. Employees went through a corrective action process and operational retraining, and breach notification letter mailed to patient. Other event handled by compliance.

Near miss fall when patient missed step for exam table, assisted by husband and NP. No injuries.

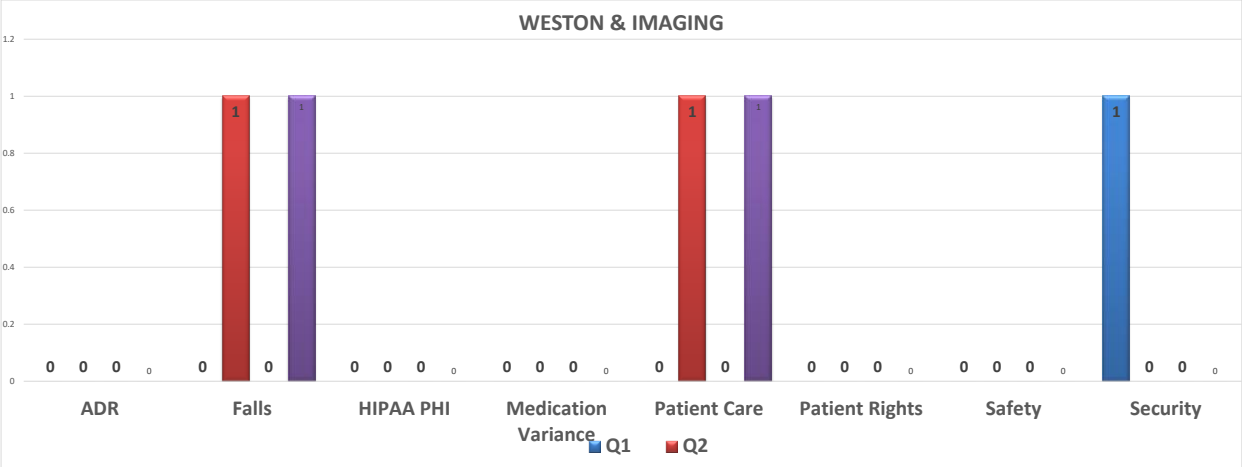
Eleven security reports received. Male individual reported being assaulted inside bathroom, police called, video footage was downloaded and reviewed by Fort Lauderdale PD, working with safety director and emergency management team to conduct drills at facility. Police arrested patient inside facility and later realized it was the wrong person. Ops manager attempted to call patient for customer service, but no phone number listed in Cerner, emergency management training requested. Police called due to individuals' altercation on property. On missing cake taker. Car damaged in parking lot. Patient granddaughter accidently recorded APRN and nutritionist, apologized and deleted it. Patient touched employee inappropriately, police contacted, panic button installed. One false panic button alarm. Missing cash reported but once investigated all was correct. Homeless sleeping by emergency door.

Three infection related. During quality rounds, outdoor biohazard 95-gallon bin found missing lock, half full of water with a used sharps container floating, handled by director of safety and security, opportunities shared with leadership regarding staff without appropriate training handling biohazards waste. Quality recommended changes of food items used and mode of storage during rounds. Patient presented to clinic after ruling out Monkey Pox hospitalization, non-detected test results.

Two safety reports. Pharmacist discovered that both freezers lost power over the weekend, vaccine manufacturers and facilities contacted, and new vaccines ordered. Quality identified electrical outlets underneath the sinks at CEB Dental, work order placed.

Lab due to wrong requisition received by lab with patient sample. Labs redraw for both patients, addressed by nurse manager.

WESTON & IMAGING	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Oct	Nov	Dec	4th Qtr	Total CY22
ADR				0				0				0				0	0
Falls				0	1			1				0			1	1	2
HIPAA PHI				0				0				0				0	0
Medication Variance				0				0				0				0	0
Patient Care				0	1			1				0			1	1	2
Patient Rights				0				0				0				0	0
Safety				0				0				0				0	0
Security			1	1				0				0				0	1
Totals	0	0	1	1	2	0	0	2	0	0	0	0	0	0	2	2	5



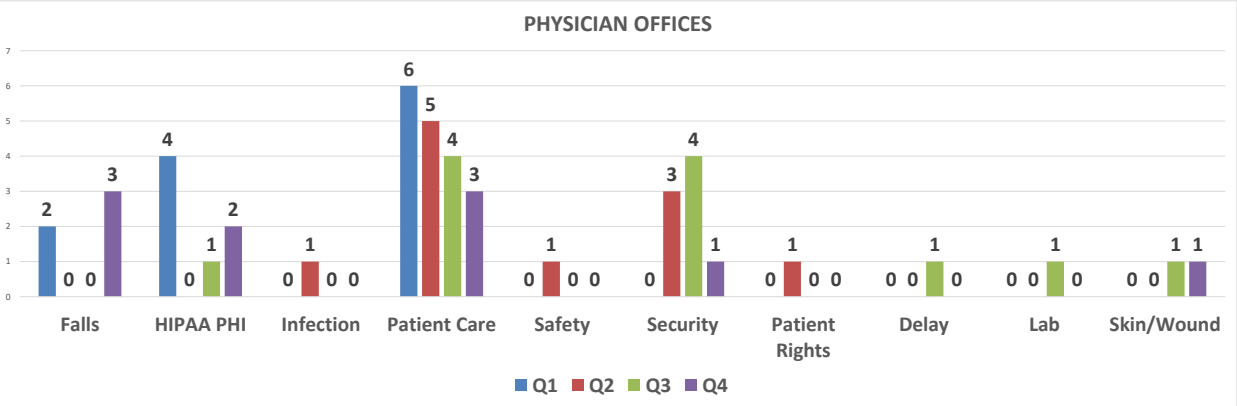
Total of 2 reports.

Visitor fall in front of elevators at lobby. Patient refused 911 and proceeded with her husband to her appoint at building tenant. Reviewed video surveillance, no hazards identified.

Patient care related to patient who complained of burning sensation during MRI due to permanent eyeliner. Screening tool includes tattoos and permanent makeup. Most pigments are made with iron oxides and lakes or other metals. MRI cancelled and patient rescheduled for CT.

Risk Manager working with Director of Operations to include 30 minutes RM presentation to next staff development meeting.

PHYSICIAN OFFICES	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Oct	Nov	Dec	4th Qtr	Total CY22
Falls		2		2				0				0		1	2	3	5
HIPAA PHI		2	2	4				0		1		1		1	1	2	7
Infection				0		1		1				0				0	1
Patient Care	3	3		6	1	3	1	5	1	2	1	4		2	1	3	18
Safety				0		1		1				0				0	1
Security				0		2	1	3	3		1	4		1		1	8
Patient Rights				0		1		1				0				0	1
Delay				0				0	1			1				0	1
Lab				0				0		1		1				0	1
Skin/Wound				0				0		1		1			1	1	2
Totals	3	7	2	12	1	8	2	11	5	5	2	12	0	5	5	10	45



Total of 10 reports.

Three falls. Patient missed step at building entrance and fell, complained of shoulder pain, examined by ortho, refused 911. Patient fell when stepping out of exam table due to decreased sensation to feet, seen by ortho and re-examined the next day, no injuries. Employee fell at BHMC parking garage, no hazards noted, referred to employee health.

Two HIPAA. Corporate Compliance received a call regarding an employee that accessed patient records without a business need, being investigated by compliance. Patient handled letter to physician regarding previous district breach, referred to compliance.

Three patient care. One patient disruptive behavior related to medication concerns which were addressed by nurse manager. One patient non-compliance with treatment plan. Patient across the waiting room complained of coughing after facilities sprayed WD40 to window track, patient with history of asthma and recent hospitalization, went to ED and was hospitalized, discussed with facilities.

Security related to patient verbal abuse who later apologized to nurse manager, behavior expectation discussed.

Patient jumped onto echo table and accidently suffered a leg skin tear which was cleaned and dressed at office.

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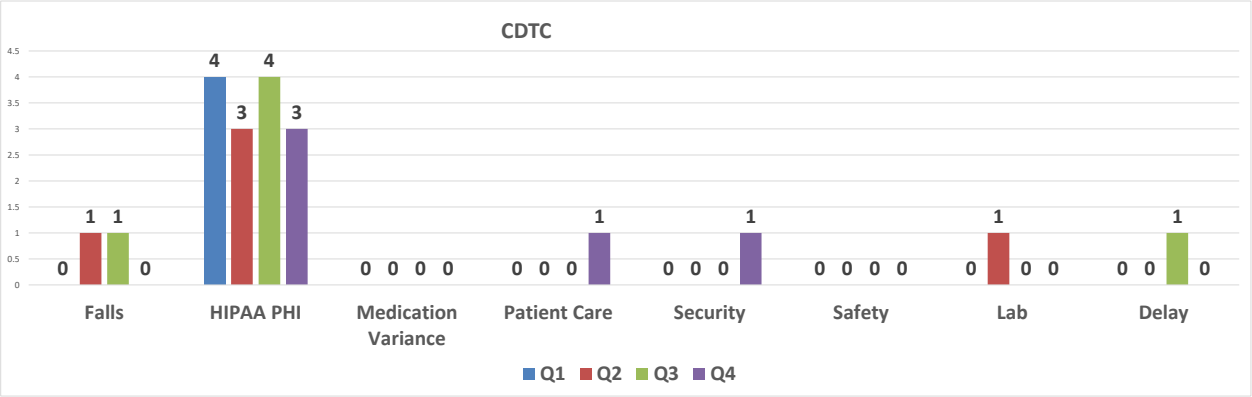
CDTC	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Oct	Nov	Dec	4th Qtr	Total CY22
Falls				0		1		1			1	1				0	2
HIPAA PHI		3	1	4	1	1	1	3		2	2	4	2	1		3	14
Medication Variance				0				0				0				0	0
Patient Care				0				0				0			1	1	1
Security				0				0				0		1		1	1
Safety				0				0				0				0	0
Lab				0		1		1				0				0	1
Delay				0				0			1	1				0	1
Totals	0	3	1	4	1	3	1	5	0	2	4	6	2	2	1	5	20



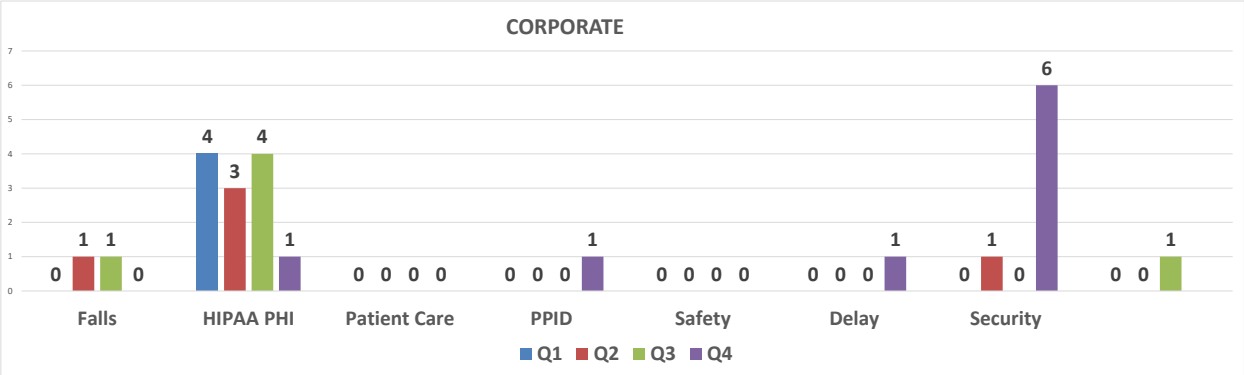
Five occurrences.

Three HIPAA. Service coordinator sent one of her families a Prior Notice Letter attached to an email with wrong patient name. IFSP form sent to BHCS by mistake. Medical records clerk sent wrong IFSP to provider. No breaches per compliance. Employees went through a corrective action process and operational retraining.

Patient care due to patient who experienced a seizure in the waiting room, evaluated by physician.

Security related to employer who brought falsified physician letter by one of patient's mother, who was previously a CDTC patient herself. Recommended behavior to be addressed with mother.

CORPORATE	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Oct	Nov	Dec	4th Qtr	Total CY22
Falls		1	1	2		3	2	5	1			1				0	8
HIPAA PHI			1	1			2	2				0	1			1	4
Patient Care			1	1				0				0				0	1
PPID				0				0				0	1			1	1
Safety	1			1				0				0				0	1
Delay					1			1							1	1	1
Security	2	1	1	4	3	2		5			4	4	1	4	1	6	19
Totals	3	2	4	9	4	5	4	13	1	0	4	5	3	4	2	9	36



Total of 9 occurrences.

HIPAA due to Health Fund Solutions vendor who had a mail merge issue that caused letters for self-pay patients to be inadvertently sent with the wrong names. Investigated by compliance.

One PPID. Nurse connect noted documentation in wrong chart, corrections made and coaching provided.

Delay related to nurse connect unable to use 3 way call with patient and 911. Issue being handled by management as Five9 does not support this.

Six security. Employee overheard another asking not to let partner in building next time, there is security at 2 Spectrum locations during business hours and visitor access has to be granted, doors require employee badges and security calls employees prior to letting visitors in. Two MVA, one involving BH vehicle, claims and insurance notified. Aggressive