BHN RISK MANAGEMENT QUARTERLY REPORT QUARTER 4

Occurrence Category CY22	Q4	%
SECURITY	235	30%
PATCARE	236	30%
SKINWOUND	39	5%
DELAY	73	9%
MEDICATION	52	7%
FALL	36	5%
SAFETY	15	2%
SURGERY	10	1%
INFECTION	5	1%
LAB	73	9%
HIPAAPHI	1	0%
ADR	3	0%
Patient Rights	1	0%
PPID	4	1%
Total	783	100%

OCCURRENCE CATEGORY CY22
Total number of events increased from 690 in Qtr 3 to 783 in Qtr 4. This is a 13.5% increase. Overall reporting remain down 2.25% from a high of 801 in Qtr 1, but appears to be steadily increasing. Patient care events remained flat with 239 events in Qtr 3 compared to 236 events in Qtr 4. Delays increased from 41 in Qtr 3 to 73 in Qtr 4, which is a 78% increase. There continues to be a significant increase in Lab reporting with 39 reports in Qtr 3 and 73 reports in Qtr 4. 48 of the Lab reports were related to Blood Products not being scanned. Overall Skin and Wound remained somewhat level with 37 reports in Qtr 3 and 39 in Qtr

Inpatient Falls by Category CY22	Q4
Found on Floor	15
Eased to Floor by Employee	1
From Bed	2
From Chair	1
Trip	1
While Ambulating	2
Slip	2
From equip, i.e. stretcher, table, etc.	1
From Bedside Commode	1
Total	26

INPATIENT FALLS BY CATEGORY CY22
Overall number of falls remained the same with 26 total in Qtr 3 and Qtr 4.
Qtr 3
- July: 12
- August: 6
- September: 8

Qtr 4
- October: 7
- November: 9

HAPIs CY22	Q4
Unstageable	4
DTI	0
Stage II	1
Stage III	0
Total	5

HAPIs CY22
- October: Two patients were identified with unstageable wounds, one to the sacrum and one to the occiput. A formal RCA was completed for the initial HAPIs identified and actions items were addressed to improve overall wound care process/monitoring. The patient identified with the unstageable to the occiput was also noted with a Stage II to the right heel.

- November: Patient was identified with an unstageable wound to the left clavicle secondary to a cervical collar device. A formal RCA was completed for this incident and multiple new action items were implemented in addition to reinforcing wound care Wednesday and wound care consult protocols already in place from the initial RCAs.

- December: The same patient with the unstageable to the left clavicle was noted to have a DTPI that evolved to an unstageable to the coccyx. RCA completed for both the left clavicle and coccyx.

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MEDICATION VARIANCES CY22	Q4
Omitted dose	6
Improper Monitoring	3
Other	4
Delayed dose	4
Prescriber Error	2
Wrong frequency or rate	1
Contraindication	3
Extra Dose	6
Pyxis Count Discrepancy	1
Pyxis Miss Fill	3
Reconciliation	2
Wrong dose	8
Wrong Drug or IV Fluid	3
Wrong Route	1
Control Drug Charting	2
Missing/Lost Medication	1
Self-Medicating	2
Total	52

MEDICATION VARIANCES CY22

Overall, the number of Medication Variances increased from 32 in Qtr 3 to 52 in Qtr 4. This is approximately a 62.5% increase in Qtr 4.

The majority of the errors reported in Qtr 4 of CY 2022 were related to Omitted doses, Extra doses given and Wrong doses of medications being ordered and/or administered.

Of note, out of 52 Medication Variances for Qtr 4, 16 of those variances were related to Pharmacy profiling medications incorrectly and 3 of the variances were related to Pyxis Miss fills.

The region conducts a monthly Medication Variance meeting to review all reports examining trends, contributing factors and lessons learned. This is a collaborative process between Risk, Quality, Nursing Leaders, Pharmacy and Administration.

No harm reported. All reports remained a Risk Severity Level I or II.

ADR CY22	Q4
Allergy	2
Hematological/Blood disorder	1
Total	3

ADR CY22

The first incident resulted in swollen gums and lips as well as a generalized rash and itching during Vancomycin administration IV. There was no documented allergy prior to this incident. Patient's EMR was updated with new allergy.

A second incident also involving Vancomycin occurred with a patient with an undisclosed allergy to the medication. The patient experienced itching as a result of the medication administration. Patient's EMR was updated to reflect new allergy.

The third incident resulted from a patient receiving IV tPa post stroke that developed gingival bleeding and bloody emesis. In this case, the medication was discontinued per MD orders due to the ADR.

SURGERY RELATED CY22	Q4
Consent Issues	4
Surgery Delay	1
Surgery Complication	2
Sterile Field Contaminated	1
Surgery/Procedure Cancelled	1
Tooth Camaged/Dislodged	1
Total	10

SURGERY RELATED CY22

Surgical related issue reporting decreased from 17 in Qtr 3 to 10 in Qtr 4. This is a 41% decrease. Out of the 10 total reports, 4 of those reports were related to Consent Issues.

In the **first case**, the MD did not include "open" to the consent for "robotic sleeve gastrectomy possible". MD was initially refusing to complete the consent process properly via e-consent. MD added word "open" and initialed next to the added verbiage along with RN and patient. Case was processed through Peer Review.

The **second issue** involved a consent for the incorrect laterality; patient needed "right" ulna fixation and consent read "left". Correct consent obtained and witnessed for procedure to the right ulna prior to procedure.

The **third case** involved a patient who stated their primary language was Spanish returned from surgery upset because he felt the procedure done was different from the one consented to. Risk team became involved and situation rectified.

The **fourth case** involved a case being booked as an "Exploratory Laparotomy" but the consent read something different. RN caught mistake prior to patient being taken to the OR. Case referred to Quality and CMO. Case ultimately sent to Peer

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SECURITY CY22	Q4
Access Control	1
Aggressive Behavior	12
Assault/Battery	1
Code Assist	14
Code Elopement	11
Contraband	30
Criminal Event	2
Elopement - Voluntary Admit	2
Property Damaged/Missing	21
Security Presence Requested	132
Security Transport	1
Trespass	3
Vehicle Accident	1
Verbal Abuse	2
Total	233

SECURITY CY22
Security events increased from 216 in Qtr 3 to 233 in Qtr 4.

The top two security events noted for Qtr 4 were "Security Presence Required" and "Contraband". The total of these two events alone is 162 which is approximately 70% of the total security events reported.

SAFETY CY22	Q4
Safety Hazard	7
Code Red	2
Sharps Exposure	3
Total	12

SAFETY CY22
Safety occurrences decreased from 16 in Qtr 3 to 12 in Qtr 4. Safety Hazard reports in particular decreased from 12 in Qtr 3 to 7 in Qtr 4.

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REGIONAL RISK MANAGEMENT SECTION : (MAY INCLUDE PERFORMANCE IMPROVEMENT INITIATIVES , SERIOUS INCIDENTS, AHCA ANNUAL REPORTABLE EVENTS, CODE 15 REPORTS, AND/OR INTENSE ANALYSIS/RCAs COMPLETED, ETC.)

BHN Performance Improvement Initiatives

FALLS Initiatives:

- Instituting of "Fall Alert" to be called with any fall that occurs in the facility
- Safety huddles every morning with Leadership team to address safety concerns and to discuss Falls house-wide
- Continue to reinforce thorough patient assessment and documentation of Morse Fall Risk Scale Score and Fall Prevention measures
- Safety sitters are assigned to all patient's who are non-compliant and a high-risk for falls
- Reinforcing hourly rounding and anticipation of patient needs to prevent falls
- Reinforcing bed alarms for all patient's documented as high-risk for falls

HAPI Initiatives:

- Wound Care Wednesdays have been instituted to encourage assessment of all patient's on the unit that have a Braden Scale score of 18 or above to ensure proper documentation and wound care is being provided
- Wound prevention audit is being traced weekly by Risk Team to ensure proper wound care/prevention is being followed for high-risk patients
- Formal RCA's are being completed for all Stage III, IV and Unstageable wounds

AHCA Annual Reportable Events

1. Fall with Hip Fracture
2. Unstageable HAPI to the Coccyx
3. Unstageable HAPI to the Coccyx and Clavicle
4. Unstageable HAPI to the Occiput

Complaints

There were 0 formal complaints filed in the 4th Quarter of CY 2022

Code 15 Reported

There were 0 code 15 reportable events in the 4th Quarter of CY 2022

Formal RCA's Completed

There were 4 formal RCA's completed in the 4th Quarter of CY 2022

RCA 1. Unstageable HAPI to the Coccyx and Left Clavicle

The patient was a 53 you male who presented to the ED via Fire Rescue as a Level 1 Trauma alert. Patient was involved in a front impact MVC with heavy front-end damage. Patient was identified to have multiple cervical spine fractures with cervical collar placement, along with fractures to the right tibia/fibula, multiple rib fractures, right scapula and clavicle fractures, right hemopneumothorax, grade 2 hepatic laceration and a traumatic injury to the right adrenal gland. Wound care was consulted for this patient due to a DTPI that evolved into an Unstageable wound on the coccyx as well as an unstageable wound to the left clavicle secondary to cervical collar placement. The patient had been intubated and admitted to the Trauma ICU from the ED. It was noted during the RCA that documentation of offloading measures were inconsistent and wound care Wednesday protocol was not being followed correctly. MD orders were also in place to maintain cervical collar in place at all times causing poor skin assessments and delayed identification of wounds.

RCA 2. Unstageable HAPI to the occiput

The patient was a 34 you male admitted on 09/26 with an intracranial hemorrhage requiring brain surgery and a craniectomy. Patient was intubated, sedated and very immobile. On 10/17 assessment revealed a Stage II wound to the right heel and an unstageable wound to the occiput, likely secondary to the helmet device in place (at all time, per MD order). Wound care consulted. Along with concerns for frequent positioning to offload heels, it was noted that MD order to keep helmet in place at all times contributed to skin breakdown and delayed identification of wound.

RCA 3. Unstageable HAPI to the Coccyx

69 year old female presents to the ER via Fire Rescue with symptoms of bilateral upper extremity and lower extremity weakness with altered speech. Patient was admitted to Neurotelemetry Inpatient unit. Shortly after admission, patient transferred to Stepdown unit due to decreased oxygenation (SpO2 88%). During her hospital stay, the patient was transferred to SICU then back to Telemetry unit until her discharge date. Due to multiple comorbities the patient underwent a cystoscopy with stents and foley catheter placement for bladder irrigation along with an emergency laparotomy with colostomy placement secondary to perforated viscus. The patient was subsequently started on TPN. On 06/3/2022 the patient was found to have blanchable erythema to the coccyx from mechanical friction injury. Wound care consulted and evaluated the patient. On 07/01/2022 the patient was seen again by wound care and noted to have developed an unstageable pressure injury to the sacrococcygeal region. On 08/06/2022 General Surgery evaluated the patient for wound debridement of the sacral ulcer. This case was only made known to the Risk Team after the patient's daughter filed a complaint with guest relations in November 2022 stating that "we killed her sister". Of note, the patient was still alive at the time of the complaint. She was discharged from BHMC to Menorah House on 08/15/2022.

HAPI RCA Opportunities

- Lack of wound care follow up unless repeat consult placed by RN
- Lack of documentation of patient refusal of Q2h turning/offloading
- Failure to maintain documentation of wound photos on admission and transfer
- Failure to perform proper offloading and/or failure to document interventions provided
- MD orders present to keep cervical collar and helmet in place at all times causing incomplete skin assessments and delayed identification of wound

FALL RCA Opportunities

- Fall alert not called overhead
- Escalation of the incident was delayed (in some cases by multiple days)
- Consults for Orthopedics post fall delayed/not called properly resulting in delay of care
- Delay in obtaining orders for post fall radiologic scans resulting in delayed dx of fracture
- Failure to implement proper fall precautions with documentation of Morse Fall Scale Score of 60-85