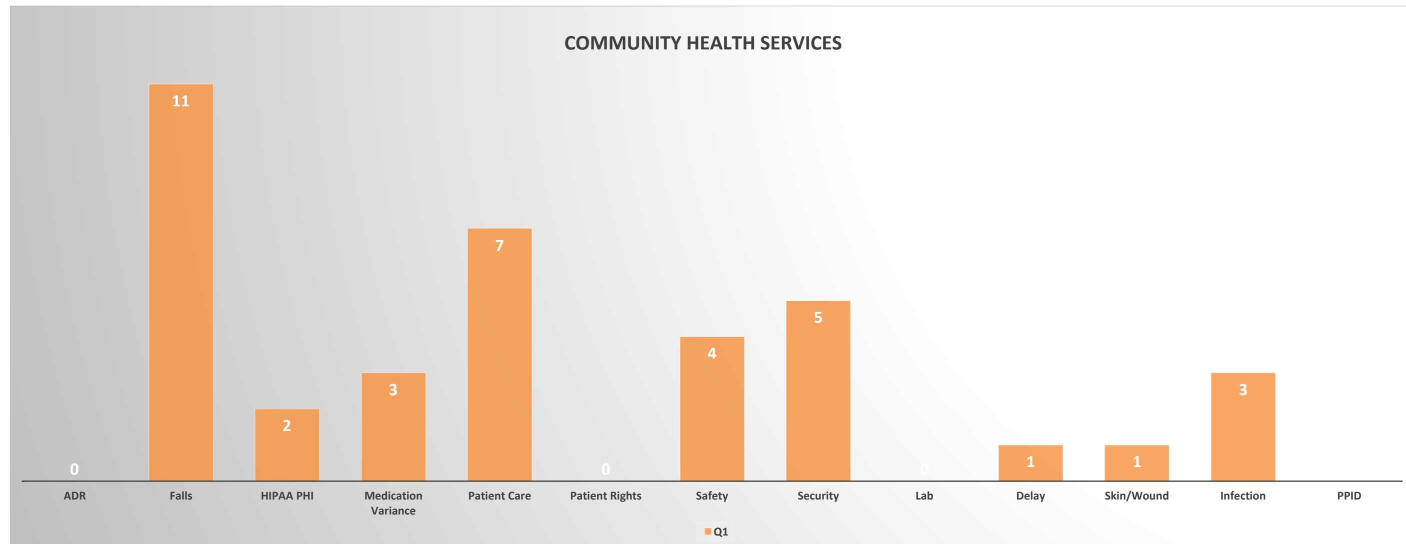
BROWARD HEALTH AMBULATORY SERVICES - RISK MANAGEMENT QUARTERLY REPORT QUARTER 1

COMMUNITY HEALTH SERVICES	Jan	Feb	Mar	1st Qtr	Total CY20
ADR	0	0	0	**0**	**0**
Falls	2	3	6	**11**	**11**
HIPAA PHI	0	0	2	**2**	**2**
Medication Variance	2	0	1	**3**	**3**
Patient Care	3	3	1	**7**	**7**
Patient Rights	0	0	0	**0**	**0**
Safety	0	2	2	**4**	**4**
Security	1	2	2	**5**	**5**
Lab	0	0	0	**0**	**0**
Delay	0	1	0	**1**	**1**
Skin/Wound	1	0	0	**1**	**1**
Infection	0	2	1	**3**	**3**
PPID	0	0	0	**0**	**0**
Totals	**9**	**13**	**15**	**37**	**37**



Total of 37 occurrences reported.

Seven of the 11 fall were home health patients, only one skin abrasion, no other injuries. One patient assisted clearing pathways at home and reminded of RW use, physician re-evaluated meds for post surgery patien.
One confuse hospice inpatient climbed out of bed, no injuties, nursing rounds increased and prn med ordered for agitation. On home hospice lost balance, no injuries and was transferred to inpatient hospice.
One prenatal patient was found on hallway floor with complaints of dizziness, was evaluated by physician, no reported injuries but transferred to ED for further evaluation.
One physician fell due to water in front of elevator with no complaints, buiding managed by DOH.

HIPAA/PHI related to follow up appointment handed to wrong patient upon discharge, front desk re-educated on proper PPID,two patients with same last name. One US report found in wrong chart, CIOX scans documentation into records, compliance monitoring these occurrences.

Three medical variances at different locations without harm to patients. One wrong drug where patient returned to pharmacy bottle of Naproxen with a few fish oil tablets. One wrong dose for Amlodipine discovered upon refill. One extra dose of flu vaccine where nurseadmitted not checking immunization history prior to administering vaccine ordered, process reinforced with nurse.

Seven patient care events. One patient became confused and then unresponsive while picking up meds at parmacy and was transported to ED.One specimen that was collected using wrong container, employee counselled and re-trainedand patient returned for second pap without charges. Two inappropriate family member behavior causing visits to be discontinued. Home hospice patient became agressive towards his wife,meeting with familyand safety plan implemented Two patient refusals of transfer to ED due to hypertension.

Four safety occurrences. Patient asked to reschedule appointment due to 2 dogs with agitated behavior. One employee report due to needle attachment breaking,device information present, reported to pharmacy who contacted manufacturer.One patient that removed mask and sneezed towards front desk person, nurse manager spoke with employee, patient was not a PUI. Home health nurse reported patient's son with flu symptoms and possible COVID exposure, appropriate steps taken, testing negative

Five security related reports. One employee car that had been broken into. One deny entry implemented due to threat of violence. Security assisted patient returning to her wheelchair. One employee identified a patient previously involved in a 2012 crime who was there for labs, case reviewed with safety and security . One missing chair from waiting area.

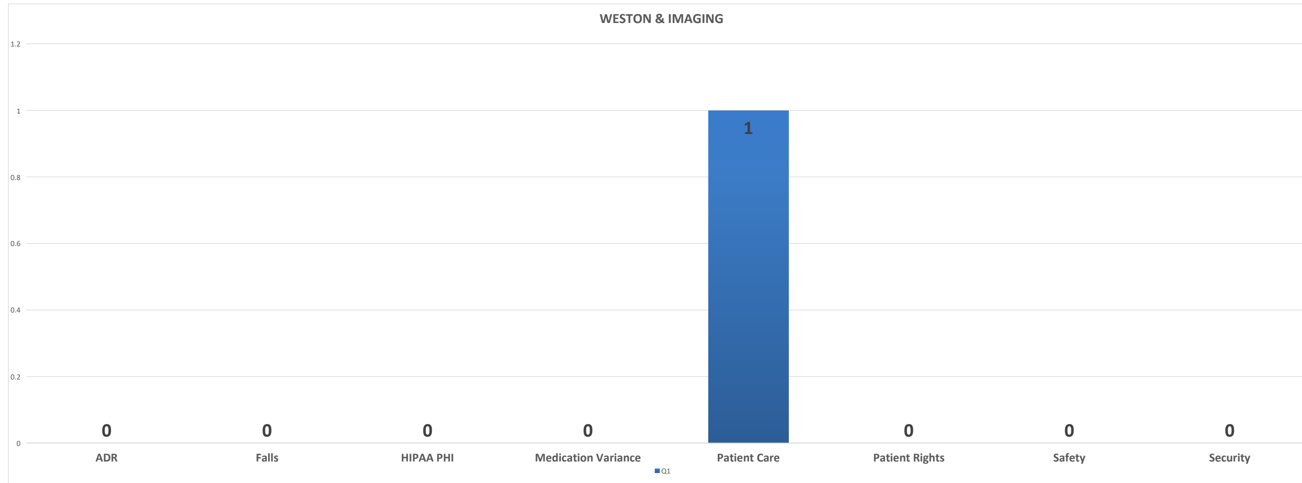
Delay to address US showing pancreatic mass. Referral for CT ordered by physician was never done due to not referral not done.Disclosure to patient during visit. Team currently usingpool for orders requiring referralswhat makes it easier to track, messages can be flaged as high importance, centralizing scheduling implemented with messages checked on a regular basis, physician to initiate administrative time to review labs, messages.Patient currently seeing surgeon.

Skin/wound repor related to patient that cut herself with nail while putting on socks.

Three infection control reports, 2 related to same occurrence. Patient presented to clinic when should be at home isolation post Tb, situation explained to patient. Administrator contacted employee health.One patient with possible COVID symptomspresented to clinicand was transferred to hospital.

Three infection control reports, 2 related to same occurrence. Patient presented to clinic when should be at home isolation post Tb, situation explained to patient. Administrator contacted employee health.One patient with possible COVID symptomspresented to clinicand was transferred to hospital.

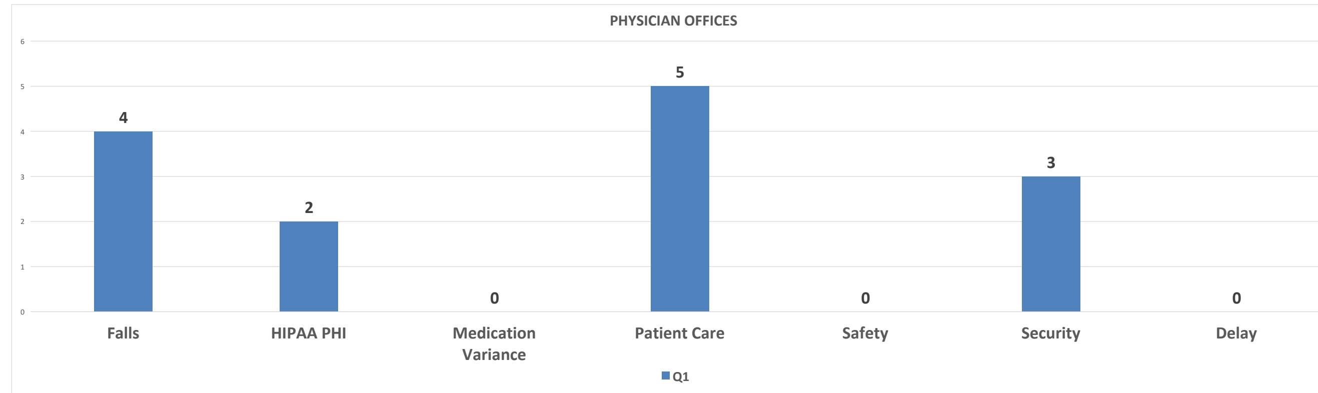
WESTON & IMAGING	Jan	Feb	Mar	1st Qtr	Total CY20
ADR	0	0	0	0	0
Falls	0	0	0	0	0
HIPAA PHI	0	0	0	0	0
Medication Variance	0	0	0	0	0
Patient Care	1	0	0	1	1
Patient Rights	0	0	0	0	0
Safety	0	0	0	0	0
Security	0	0	0	0	0
Totals	1	0	0	1	1



Only one occurrence reported with significant decrese compared to previous quarter (7). Possible causes for fewer reports could be restructure of UCCs with new hires and retirement of radiology manager. Risk manager participated at staff meeting on March 3 reinforcing HAS reporting of occurrences and grievances.

Urgent care team initiated needed treatment for respiratory distress of 17 year old prior to registering patient with verbal consent from parents and called rescue for transfer to hospital ED.Family came from a park without ID of form of payment. Staff informed to always register patient and obtain written consent for treatment.

PHYSICIAN OFFICES	Jan	Feb	Mar	1st Qtr	Total CY20
Falls	2	1	1	4	4
HIPAA PHI	0	1	1	2	2
Medication Variance	0	0	0	0	0
Patient Care	0	4	1	5	5
Safety	0	0	0	0	0
Security	1	0	2	3	3
Delay	0	0	0	0	0
Totals	3	6	5	14	14



Total of 14 occurrences. Increase from 9 during previous quarter.

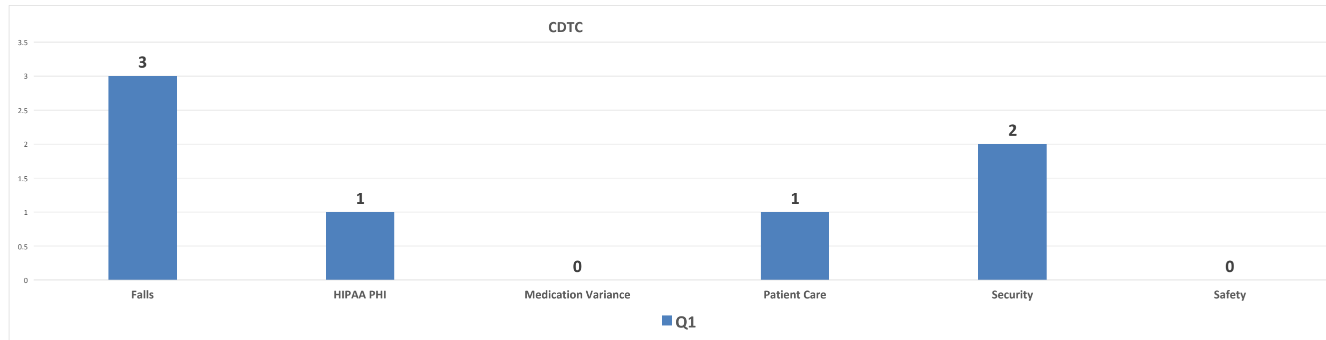
Four patient falls. One patient fell trying to get to exam table during intake, no injuries or complaints.
Other patient had witnessed fall from chair as he fainted while Metronic tech was performing pacemaker interrogation, assessed by physician. Family refused 911 and they reported no injuries. Patient nor his family was appropriately informed of the possible side effects of pacer maker interrogation. Nurse manager counseled the that moving forward patients being seen for pacer interrogation mustT be placed in exam room withrecliner/exam table prior to procedure being done. If an exam room with an recliner/exam table is not available, then an additional caregiver (MA, LPN, or RN) will be required to be in the room with the patient and pacer tech during the procedure. This protocol will ultimately be implemented in all our Cardiology offices that conduct pacemaker interrogations as a standard of practice. A memorandum must also be sent to all pacemaker interrogation Representatives informing them of our change in practice.
Sixteen year old fainted when stood up from exam table, 911 evaluated patient but family member refused transfer to ED as patient fell better, no injuries.

HIPAA/PHI involved two wrong patients billed, corrections made. One event related to incorrect guarantor attached to patient's chart. Compliance aware.

Total of 5 patient care issues. One patient became unresponsive during intake at palliative care office, rapid response called and patient transferred to ED. One 18 year old presented to GI office with SOB and hyperglycemis, 911 called and patient taken to ED. One patient stated feeling suicidal during intake, was evaluated by physicianwho stayed with patient till 911 arrive totransport to hospital. One patient complained of acute anxiety accompanied of other symptoms and was transferred to ED by rescue. One patient disruptive behavior at parking lot.

Patient security occurrences reported one agressive behavior and one verbal abuse. Police called but arrived after patient had left, patient was ofered other physician options. Deny entry and termination of physician-patient relationship for one patient. Property missing related to physician office that is tenant at building.

CDTC	Jan	Feb	Mar	1st Qtr	Total CY20
Falls	1	2	0	3	3
HIPAA PHI	0	0	1	1	1
Medication Variance	0	0	0	0	0
Patient Care	1	0	0	1	1
Security	1	0	1	2	2
Safety	0	0	0	0	0
Totals	3	2	2	7	7



Total of 7 occurrences reported.

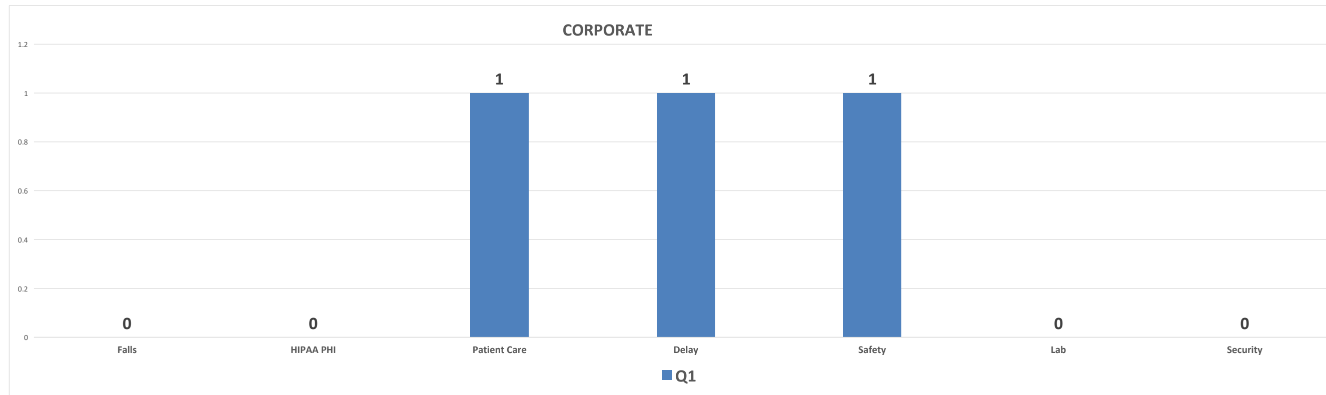
Two patients and one volunteer fall. One child hit head in bathroom sustained a small cut near eyebrowthat was assessed and cleaned by physicianand sent patient to ED where he receivedstiches. Fourty three year old patient found on bathroom floor after syncope episode, physician assisted patient and called 911 but patient refused transport to ED, no reported injuries. Volunteer fell when shopping cart she was carrying triped in parking garagewith no injuries.

HIPAA/PSI event related to wrong patient form emailed to Early Steps provider who was notified of error and was asked to delete information.Compliance aware.

Patient care event involved child activity injury, small scratch not requiring treatment.

Security categories were patient verbal abuse and patient aggressive behavior. Later required police to be called with BA and transfer to ED, decision to discharge 21 year old male patient from the practice for safety reasons, references for continuation of care provided.

CORPORATE	Jan	Feb	Mar	1st Qtr	Total CY20
Falls	0	0	0	0	0
HIPAA PHI	0	0	0	0	0
Patient Care	0	0	1	1	1
Delay	0	1	0	1	1
Safety	1	0	0	1	1
Lab	0	0	0	0	0
Security	0	0	0	0	0
Totals	1	1	1	3	3



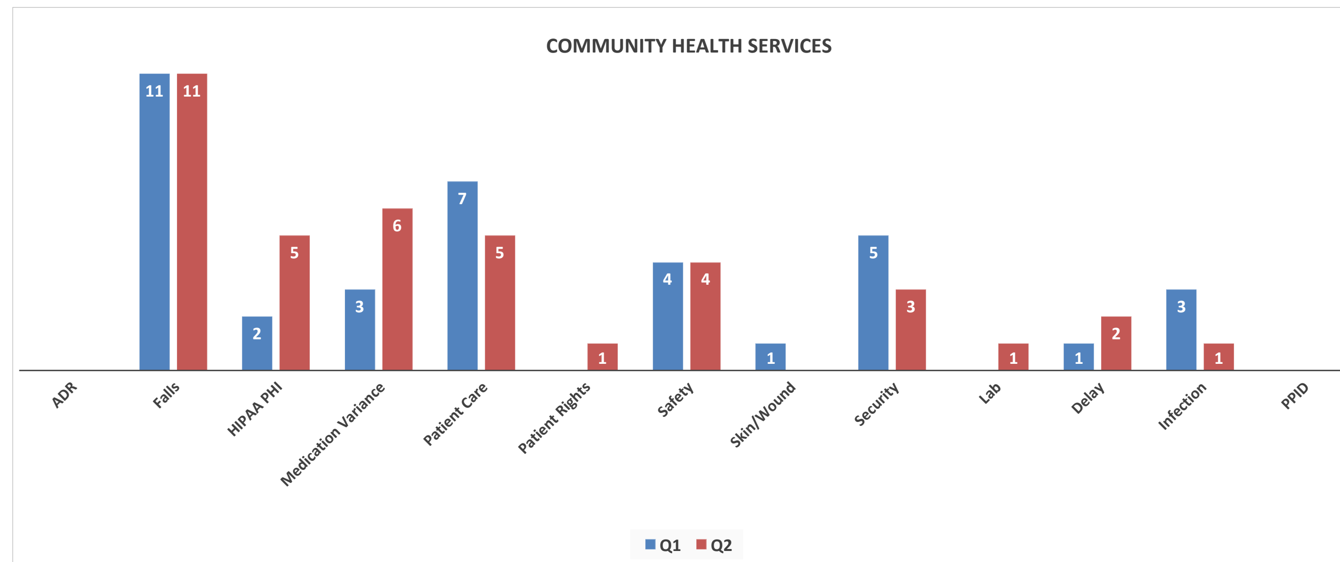
Three corporate occurrence reports for first quarter.

Patient care occurrence involved patient tested at COVID-19 drive thru called by MA with wrong results. Patient had tested positive as evidenced by results tab and DETECTED result in Pools message. Patient checked portal and noted that the results were not consistent. She called RN Connect. RN reviewed patient's medical record and noted the POSITIVE result. Physician called patient back and discussed the positive results with her. Patient was satisfied with the call. Physician recalled other cases with same error but different MAs. MA had made other calls without mistakes before and after this one. Decision that only RNs would call patients with results as they always open results tab to confirm it before placing calls to prevent reoccurrence.

Employee reported safety occurrence related to getting printer ink toner into her eyes.Reported to worker's compensation and seen at ED.

Delay event belonged to BHMC and was referred to them and initiated IT request for change from BHCO to BHBG.

COMMUNITY HEALTH SERVICES	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	Total CY20
ADR	0	0	0	0	0	0	0	0	0
Falls	2	3	6	11	1	5	5	11	22
HIPAA PHI	0	0	2	2	2	1	2	5	7
Medication Variance	2	0	1	3	5	1	0	6	9
Patient Care	3	3	1	7	0	4	1	5	12
Patient Rights	0	0	0	0	1	0	0	1	1
Safety	0	2	2	4	0	3	1	4	8
Skin/Wound	1	0	0	1	0	0	0	0	1
Security	1	2	2	5	0	1	2	3	8
Lab	0	0	0	0	0	0	1	1	1
Delay	0	1	0	1	0	2	0	2	3
Infection	0	2	1	3	1	0	0	1	4
PPID	0	0	0	0	0	0	0	0	0
Totals	9	13	15	37	10	17	12	39	76



Total of 39 occurrences reported.

Ten of the 11 falls were from Gold Coast, 9 home health and one home hospice. One patient had syncopal episode s/p bypass surgery, suffered facial bone fracture that did not require intervention. Four falls resulted in minor injury. All patients receiving PT services and fall prevention education.

Five HIPAA/PHI reports, one duplicate, all different facilities. Compliance enforcing their policy GA-004-160 Sanctions for Non-Compliance with Information Privacy and Security Policies. In accordance with this policy whenever there are HIPAA violations, the employee's manager is to reach out to HR for a corrective action. HR determines corrective action.

Six medication variances. One wrong patient (PPID policy reinforced), 3 wrong dose (provider instructed on best drop down option for ordering to reduce profiling error), 2 duplicate therapy (pharmacists reminded of importance of med reconciliation). No harm to patients.

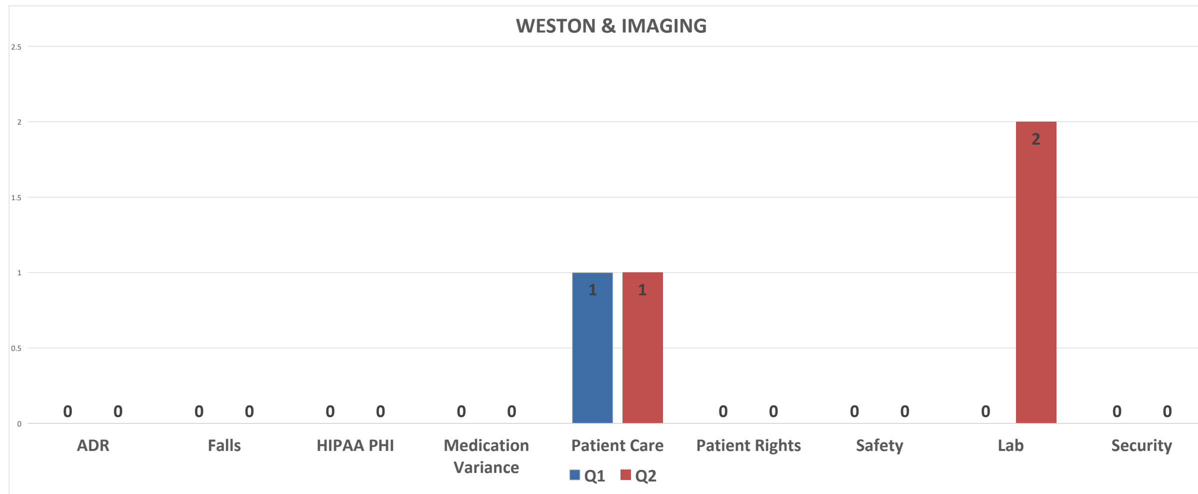
One patient care event was related to patient with multiple medical records. Registration of patients as per DL reinforced. Two patients required BA.

Safety occurrences included vaccine freezer temperature outside required limits (proper steps taken), one related to COVID-19 positive patient, one employee needle stick due to patient move (reported to employee health).

Delay occurrences related to Gold Coast. No harm to patients.

Infection events reported patient who presented to clinic when should be at home isolation post Tb. Other patient with possible COVID symptoms presented to clinic and was transferred to hospital.

WESTON & IMAGING	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	Total CY20
ADR	0	0	0	0	0	0	0	0	0
Falls	0	0	0	0	0	0	0	0	0
HIPAA PHI	0	0	0	0	0	0	0	0	0
Medication Variance	0	0	0	0	0	0	0	0	0
Patient Care	1	0	0	1	0	0	1	1	2
Patient Rights	0	0	0	0	0	0	0	0	0
Safety	0	0	0	0	0	0	0	0	0
Lab	0	0	0	0	0	1	1	2	2
Security	0	0	0	0	0	0	0	0	0
Totals	1	0	0	1	0	1	2	3	4

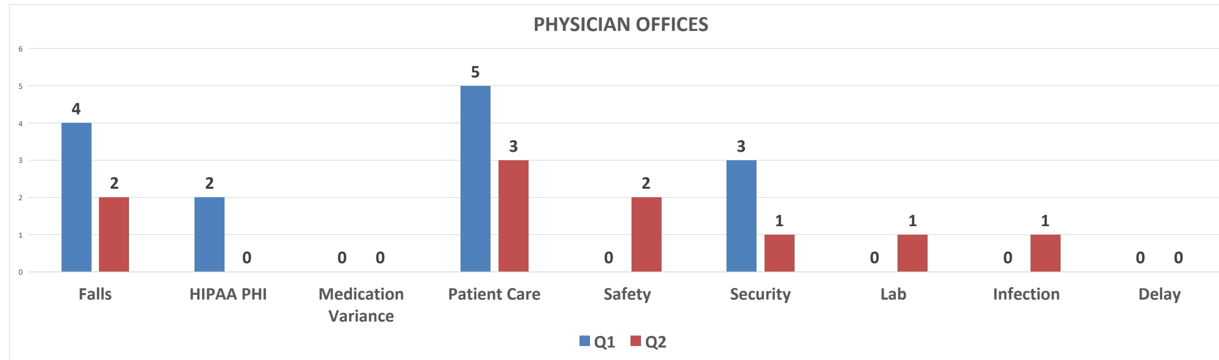


Three occurrences reported.

Patient care due to abnormal CT brain result at imaging center and patient transfer to ED.

One Lab occurrence related to specimen for trichomoniasis collected in a way BHMC could not process, patient contacted but already on medication, nurse manager informed all UCC's staff that it should be a urine specimen to be sent to BHMC. Other related to UCC not realizing that patient needed swab test instead of antibody test ordered by surgeon for surgery pre-op. Patient returned without additional charge.

PHYSICIAN OFFICES	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	Total CY20
Falls	2	1	1	4	1	1	0	2	6
HIPAA PHI	0	1	1	2	0	0	0	0	2
Medication Variance	0	0	0	0	0	0	0	0	0
Patient Care	0	4	1	5	0	1	2	3	8
Safety	0	0	0	0	1	0	1	2	2
Security	1	0	2	3	0	1	0	1	4
Lab	0	0	0	0	1	0	0	1	1
Infection	0	0	0	0	0	1	0	1	1
Delay	0	0	0	0	0	0	0	0	0
Totals	3	6	5	14	3	4	3	10	24



Total of 10 occurrences reported.

Two falls. One patient slid out of the chair and was able to stand unassisted. One visitor fal. No injuries.

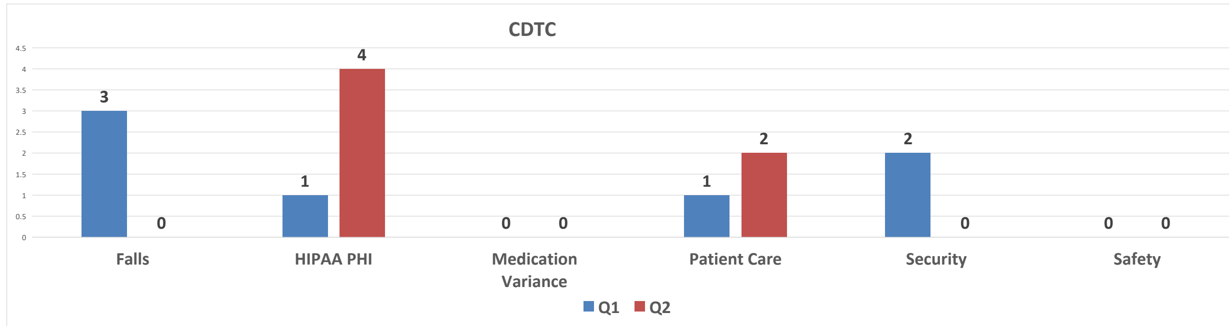
Three patient care events. One x ray misread referred to medical peer review at BHMC .Pediatric patient self injury reported to physician. Allegations of inappropriate care provided by physicianreceived from patient's spouse, reviewed by CMO and care deemed appropriate.

Safety event due to physician needle stick while recaping needle. Employee health notified. BHPG nurse managers to ensure that the offices have safety needles/devices and if possible dispose needles/syringes without proper safety devices.

Lab related to wrong patient label. MA had already called Quest for pick up when patient was drawn. MA was rushing and left purple tube in the centrifuga. According to Quest tube could still be sent when MA realized error. This time MA printed the wrong patient label to send to Quest with purple tube. When physician reviewed results in the afternoon, noted she got 2 CBCs for the same patient, she realized error based on patient's history and addressed correctly. Nurse manager addressed errors with MA.

Infection control occurrence should had been entered as complaint about x ray tech not wearing mask during procedure with patient. Nurse manager contacted patient. Employee counseled.

CDTC	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	Total CY20
Falls	1	2	0	3	0	0	0	0	3
HIPAA PHI	0	0	1	1	0	0	4	4	5
Medication Variance	0	0	0	0	0	0	0	0	0
Patient Care	1	0	0	1	0	1	1	2	3
Security	1	0	1	2	0	0	0	0	2
Safety	0	0	0	0	0	0	0	0	0
Totals	3	2	2	7	0	1	5	6	13

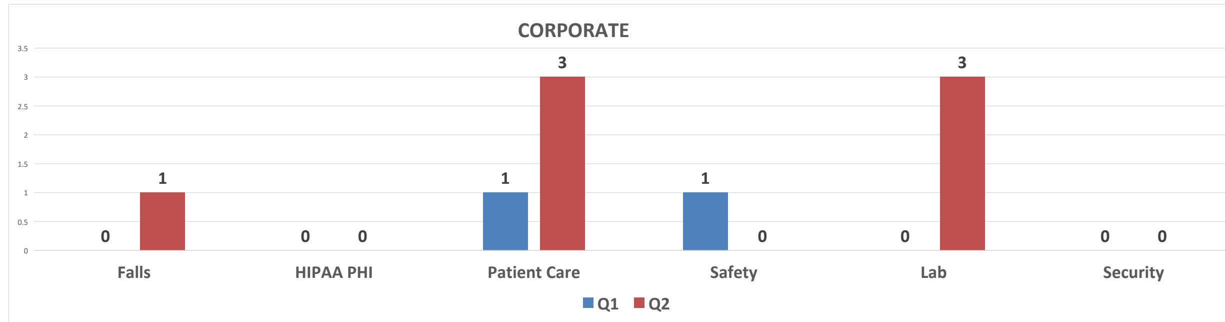


Total of 6 occurrences.

Two of the 4 HIPAA/PHI events reported Early Steps form mailed to wrong provider. Compliance held educational session with staff.

Patient care occurrence related to patient allegations against provider that were not substantiated.Also one patient reported abuse at home during visit with provider and DCF was contacted.

CORPORATE	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	Total CY20
Falls	0	0	0	**0**	0	1	0	**1**	**1**
HIPAA PHI	0	0	0	**0**	0	0	0	**0**	**0**
Patient Care	0	0	1	**1**	3	0	0	**3**	**4**
Safety	1	0	0	**1**	0	0	0	**0**	**1**
Lab	0	0	0	**0**	1	2	0	**3**	**3**
Security	0	0	0	**0**	0	0	0	**0**	**0**
Totals	**1**	**0**	**1**	**2**	**4**	**3**	**0**	**7**	**9**



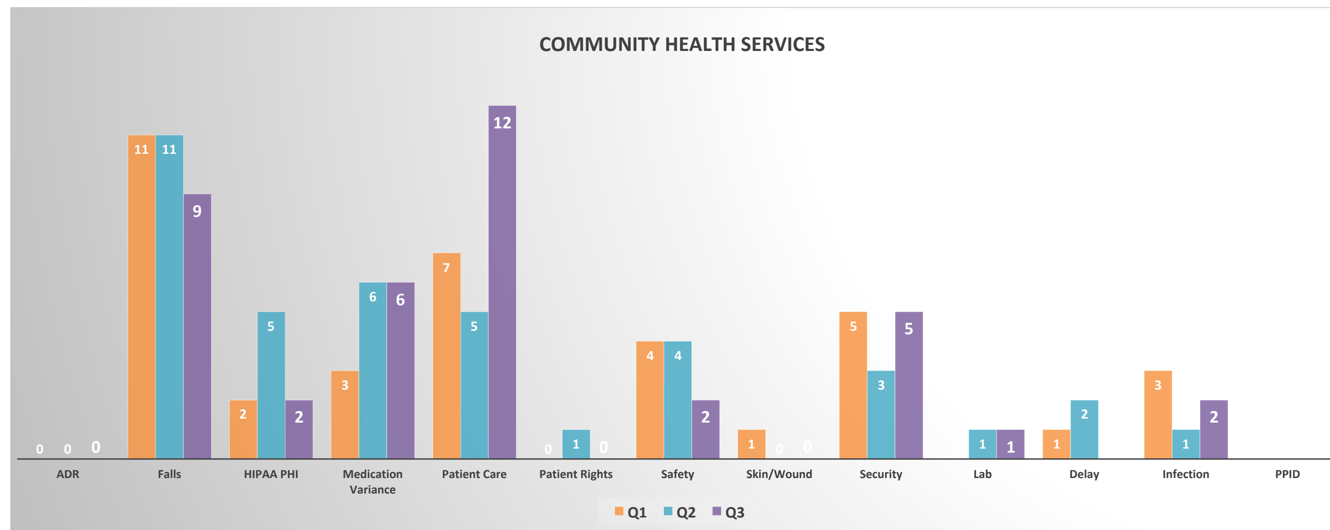
Seven occurrences reported.

One visitor fall outside ISC building, no environmental issues identified or injuries reported.

Three patient care events related to COVID-19 testing sites.One patient presented with SOB and was transferred to ED. Part of swab stayed logged in patient's nare requiring transfer to ED, DOH who provides swabs was notified, claims department notified as patient would like BH to pay for ED visit. RN misread COVID result and called patient with negative when patient was positive, this was discovered during end day positive results review, RN realized short cut should not been used as previously discussed.

Three lab occurrences related to COVID-19 testing sites. Quest reported receiving specimens for one patient with requisitions for another patient, patients were retested, requisition printing process evaluated.No similar events since May.

COMMUNITY HEALTH SERVICES	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Total CY20
ADR	0	0	0	0	0	0	0	0	0	0	0	0	0
Falls	2	3	6	11	1	5	5	11	2	4	3	9	31
HIPAA PHI	0	0	2	2	2	1	2	5	0	0	2	2	9
Medication Variance	2	0	1	3	5	1	0	6	3	1	2	6	15
Patient Care	3	3	1	7	0	4	1	5	5	5	2	12	24
Patient Rights	0	0	0	0	1	0	0	1	0	0	0	0	1
Safety	0	2	2	4	0	3	1	4	1	0	1	2	10
Skin/Wound	1	0	0	1	0	0	0	0	0	0	0	0	1
Security	1	2	2	5	0	1	2	3	1	2	2	5	13
Lab	0	0	0	0	0	0	1	1	1	0	0	1	2
Delay	0	1	0	1	0	2	0	2	0	0	0	0	3
Infection	0	2	1	3	1	0	0	1	1	0	1	2	4
PPID	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	9	13	15	37	10	17	12	39	14	12	13	39	115



Sevenof the 9 falls were from Gold Coast , 5 Home Health, 2 Home Hospice. Three falls resulted in minor injury. All patients receiving PT services and fall prevention education. One CHS visitor fall and one patient near miss fall. Visitor related to syncopal episode. Patient near miss while stepping out of scale.
Two patient care from Home Health. One infection Control related to patient who tested positive for COVID.

Two HIPAA/PHI reports. Wrong discharge papers discovered at pharmacy, PPID reinforced with nurse. Patient presented to US with papers for another patient.PPID assessment completed with employee followed by monitoring.

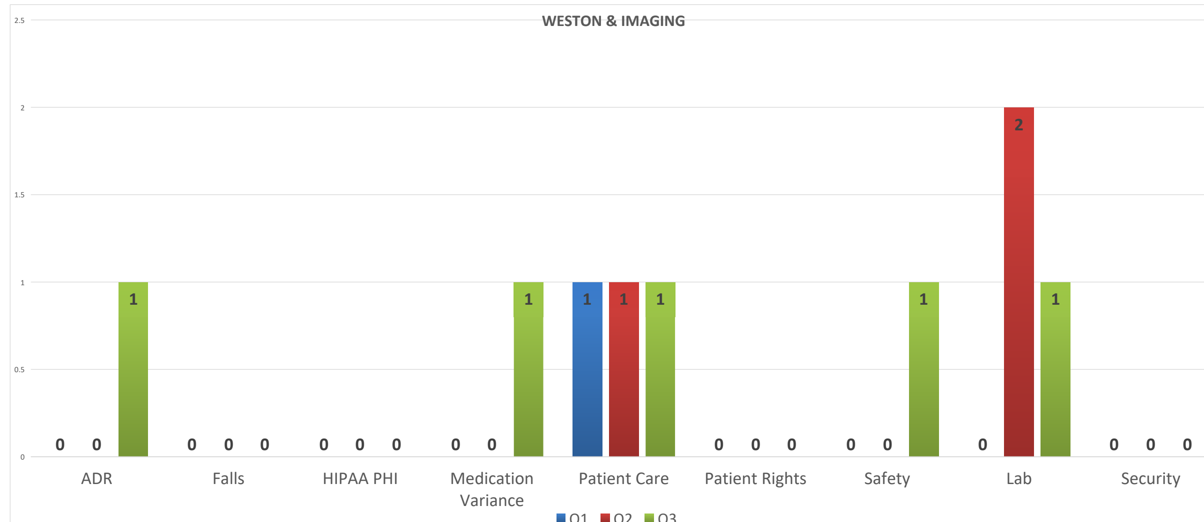
Six medication variances. Two patients received PPD instead of Tdap. Patients contacted to return for vaccine ordered. MA asked assistance from senior MA who misunderstood her accent and administered PPD. MA repeated the error on another patient. Nurse coordinator met with both MAs and implemented two person checks against order before any medication administration. One patient called pharmacy to question oyster shell calcium + D that she received as she has shellfish allergy which was previously documented on chart. The pharmacists were reminded to pay close attention to allergies prior to verifying a script and drug utilization reviews in pharmacy's software which flags patient allergies in comparison to drugs prescribed when a contraindication is determined. In the event that a pharmacist is interrupted while verifying a script as in this scenario, upon return, the pharmacist should restart the verification process in order to decrease the chances of an occurrence like this happening again. One related to prescription sent to Walgreens for patient's mother instead of patient. Same first and last names on system, both DOB in January. Nextgen added daughter's middle name Lazo. Employee coached on use of 2 identifiers to initiate order. Two wrong doses (Ibuprofen, Metformin) filled, no harm.

Lab event related to LabCorp not locating specimen, patient contacted to return (CEB UCC patient).

CHS Infection event reported patient who presented to clinic positive for Tb. Patient presented to ED and employee health notified.

Safety event reported dentist finger cut when using matrix band . Consider using different band and double gloving. Other reported wrong x ray report. Investigated by radiology, physician was viewing one patient's images but documented under another. Addendum completed and APRN followed up with patient, no harm. Forward to regional radiology managr.

WESTON & IMAGING	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Total CY20
ADR	0	0	0	0	0	0	0	0	0	1	0	1	1
Falls	0	0	0	0	0	0	0	0	0	0	0	0	0
HIPAA PHI	0	0	0	0	0	0	0	0	0	0	0	0	0
Medication Variance	0	0	0	0	0	0	0	0	0	1	0	1	1
Patient Care	1	0	0	1	0	0	1	1	1	0	0	1	3
Patient Rights	0	0	0	0	0	0	0	0	0	0	0	0	0
Safety	0	0	0	0	0	0	0	0	0	1	0	1	1
Lab	0	0	0	0	0	1	1	2	0	1	0	1	2
Security	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	1	0	0	1	0	1	2	3	1	4	0	5	8



ADR due to patient with hives after Optiray 320 at Weston Imaging, resolved.

Medication event related to documentation and did not affect patient.

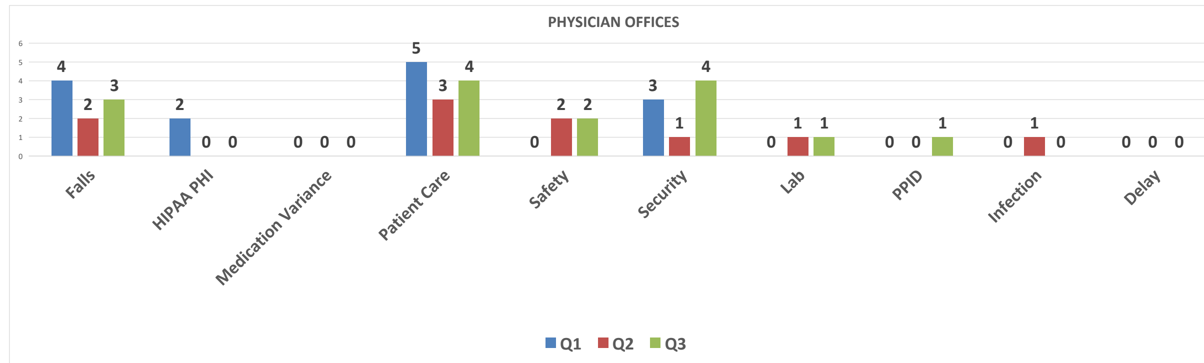
Patient care related to abnormal CT brain result at imaging center and patient transfer to ED. Other AMA.

One Lab occurrence related to UCC not realizing that patient needed swab test instead of antibody test ordered by surgeon for surgery pre-op. Patient returned without additional charge. Other due to Quest not locating specimen. Patient called to redo it without charges.

Safety event reported employee who cut finger while removing cast, employee health notified.

Security related to patient's inappropriate behavior.

PHYSICIAN OFFICES	Jan	Feb	Mar	1st Qtr	Apr	May	June	d Qt	July	Aug	Sept	d Qt	Total CY20
Falls	2	1	1	4	1	1	0	2	1	1	1	3	9
HIPAA PHI	0	1	1	2	0	0	0	0	0	0	0	0	2
Medication Variance	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Care	0	4	1	5	0	1	2	3	2	1	1	4	12
Safety	0	0	0	0	1	0	1	2	2	0	0	2	4
Security	1	0	2	3	0	1	0	1	3	1	0	4	8
Lab	0	0	0	0	1	0	0	1	1	0	0	1	2
PPID	0	0	0	0	0	0	0	0	0	0	1	1	1
Infection	0	0	0	0	0	1	0	1	0	0	0	0	1
Delay	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	3	6	5	14	3	4	3	10	9	3	3	15	39



One employee fall without injuries. One patient fall due to feeling weak at building lobby, no injuries.Other patient appeared to have a syncopal event, suffered small abrasionand refused transfer to ED.

Four patient care events. One report that patient expired at BHIP on same day of office visit. Care reviewed by medical director as appropriate. Suggestion for these patients with higher level of acuity to be seen by physician or for APRN to bring in physician at end to see patient and review recommendations. APRN can then document consultation. Two unstable patients transferred to hospital. One disruptive patient.

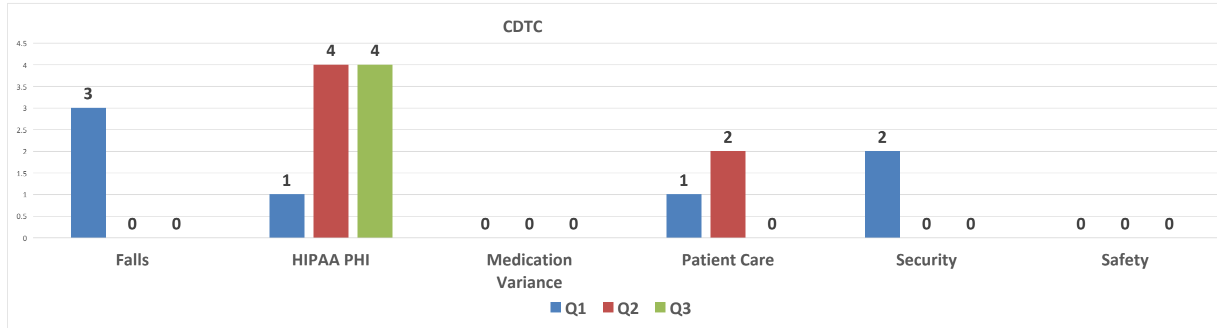
Two safety events related to needle stick. BHPG nurse managers to ensure that the offices have safety needles and if possible dispose needles/syringes without proper safety device. Other near miss when MA almost got stuck with new Saf-T wing butterfly, stated this had happened before. Education department arranged for rep visit with in service.

Three of the four security occurrences related to patient aggressive behavior.Other related to missing supplies so supplies moved to other locked area.

Lab related to physician mishandling of specimen. PCPs should be sending patients to testing sites instead of testing them for COVID-19 at the office. VP Clinical Services will address issue with compliance.

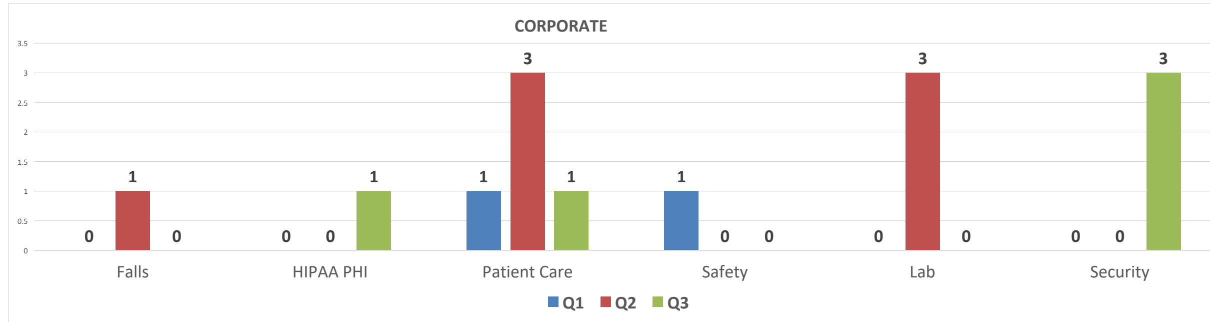
PPID related to encounter billed under wrong patient. Same name. Bills corrected and employee reinstructed on using two patient identifiers.

CDTC	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Total CY20
Falls	1	2	0	3	0	0	0	0	0	0	0	0	3
HIPAA PHI	0	0	1	1	0	0	4	4	3	1	0	4	9
Medication Variance	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Care	1	0	0	1	0	1	1	2	0	0	0	0	3
Security	1	0	1	2	0	0	0	0	0	0	0	0	2
Safety	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	3	2	2	7	0	1	5	6	3	1	0	4	17



Three of the four HIPAA/PHI events reported Early Steps form sent to wrong provider. One report sent to wrong fax number. Compliance held educational session with staff.

CORPORATE	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Total CY20
Falls	0	0	0	0	0	1	0	1	0	0	0	0	1
HIPAA PHI	0	0	0	0	0	0	0	0	1	0	0	1	1
Patient Care	0	0	1	1	3	0	0	3	0	1	0	1	5
Safety	1	0	0	1	0	0	0	0	0	0	0	0	1
Lab	0	0	0	0	1	2	0	3	0	0	0	0	3
Security	0	0	0	0	0	0	0	0	0	3	0	3	3
Totals	1	0	1	2	4	3	0	7	1	4	0	5	14

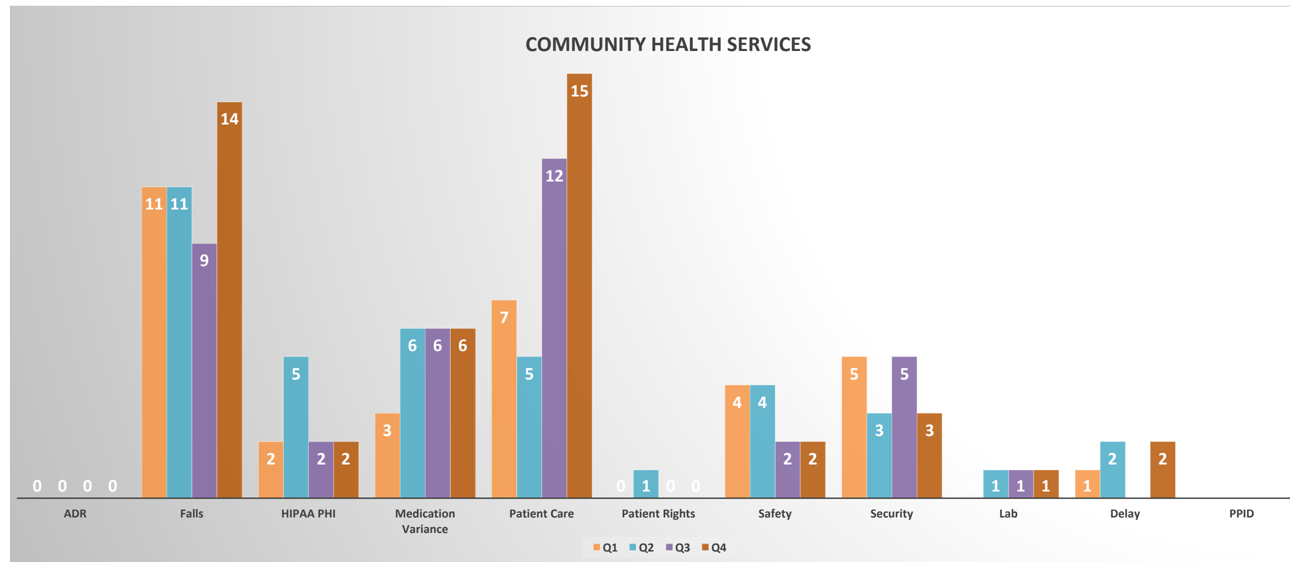


HIPAA/PHI occurrence related to bill sent to wrong insurance by managed care.

One employee clinical event.

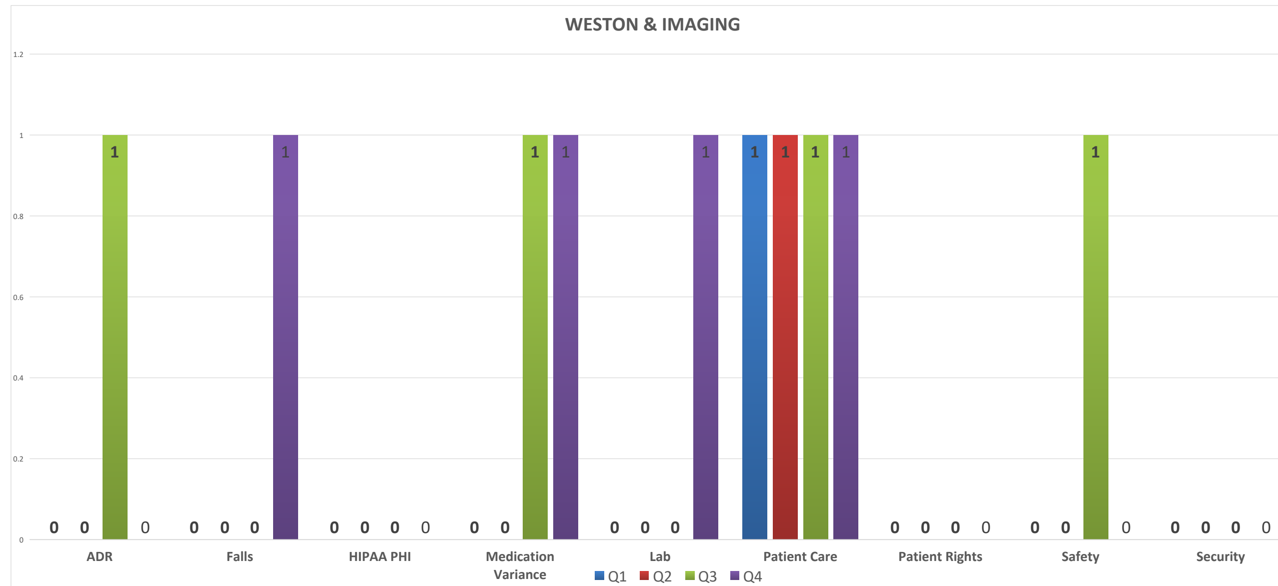
Security events managed by security.

COMMUNITY HEALTH SERVICES	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Oct	Nov	Dec	4th Qtr	Total CY20
ADR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Falls	2	3	6	11	1	5	5	11	2	4	3	9	2	5	7	14	45
HIPAA PHI	0	0	2	2	2	1	2	5	0	0	2	2	1	0	1	2	11
Medication Variance	2	0	1	3	5	1	0	6	3	1	2	6	0	3	3	6	21
Patient Care	3	3	1	7	0	4	1	5	5	5	2	12	5	6	4	15	39
Patient Rights	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1
Safety	0	2	2	4	0	3	1	4	1	0	1	2	1	1	0	2	12
Security	1	2	2	5	0	1	2	3	1	2	2	5	1	1	1	3	16
Lab	0	0	0	0	0	0	1	1	1	0	0	1	0	1	0	1	3
Delay	0	1	0	1	0	2	0	2	0	0	0	0	1	1	0	2	5
PPID	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	9	13	15	33	9	17	12	38	13	12	12	37	11	18	16	45	157



Total of 45 events.
Nine of the 14 falls were from Home Health and one from Inpatient Hospice family member. Patients were receiving PT services. One patient suffered a hip fracture and was transferred to hospital. Fall precautions reinforced. Home Health's two medication variances involved one delayed and one omitted dose. Hospice Home was one extra dose by family member. Locked box used to store meds at home with key managed by caregiver, daily narcotic count by nursing staff with documentation on visit note. Process was reinforced with family.
Three employee falls, no injuries, one duplicate. Noted some light posts were out, these were repaired by facilities. Other employee fell at curb while crossing street, employee health notified, no issues with pavement. One prenatal patient tripped on waiting room chair, no injuries.
HIPAA involved wrong discharge papers provided to patient, corrected immediately, human error addressed by nurse manager.
Medication variances were related to wrong dose . Information on appropriate way to change National Drug Codes by using drop menu for drug dispensed instead of changing medication written was shared at pharmacy huddle. Two medications had been placed on file to be clarified and old dosage was dispensed. Problem box implemented at pharmacy for follow up if any issues with prescriptions.
Four patient care occurrences were AMAs. Three related to patient/family disruptive behavior. One patient rapid response, patient seen by provider and transferred to hospital. One patient attempted suicide while waiting to be transported to behavioral health facility. Security who was sitting with patient acted immediately and there was no injury, patient transferred. Risk assessments are being conducted at CHS clinics to evaluate areas best suited for BA patients.
One safety event reported that provider regularly stays late at clinic leading to security overtime, addressed by safety and security. One false fire alarm, no issues identified.
Lab occurrence due to specimens not collected by courrier when clinic closed earlier. Patients returned without charges. Nurse/MA assigned to the lab has daily responsibility for ensuring that the lab is picked up. If they leave prior to pick up, they must inform a colleague and/or security so that someone can ensure that the pick-up occurs.Verification End-of-Shift Lab Specimen Pick-up Log implemented.

WESTON & IMAGING	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Oct	Nov	Dec	4th Qtr	Total CY20
ADR	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1
Falls	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1
HIPAA PHI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medication Variance	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	1	2
Lab	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1
Patient Care	1	0	0	1	0	0	1	1	1	0	0	1	0	1	0	1	4
Patient Rights	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Safety	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1
Security	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	1	0	0	1	0	0	1	1	1	3	0	4	1	1	2	4	10



Total of 4 events reported.

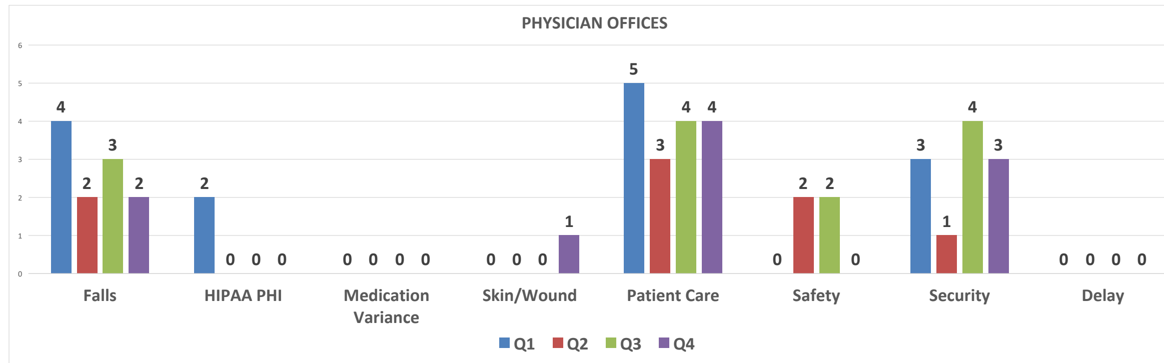
One accidental patient fall on hall to radiology, no injuries.

One specimen sent to wrong lab reported but after investigation noted that it was correct lab according to patient's insurance.

Patient care due to radiology misread of fracture. Referred to BHMC peer review committee after physician review.

Medication event due to wrong dose, no harm to patient.

PHYSICIAN OFFICES	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Oct	Nov	Dec	4th Qtr	Total CY20
Falls	2	1	1	4	1	1	0	2	1	1	1	3	1	1	0	2	11
HIPAA PHI	0	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Medication Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Skin/Wound	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1
Patient Care	0	4	1	5	0	1	2	3	2	1	1	4	3	0	1	4	16
Safety	0	0	0	0	1	0	1	2	2	0	0	2	0	0	0	0	4
Security	1	0	2	3	0	1	0	1	3	1	0	4	1	1	1	3	11
Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	3	6	5	14	2	3	3	8	8	3	2	13	6	2	2	10	45



Total of 10 events reported.

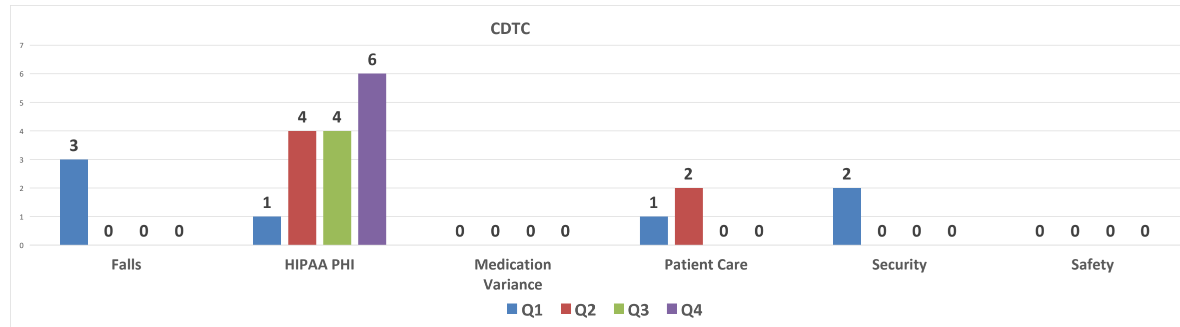
One family member fall from his car in parking lot, transferred to hospital by rescue. One patient fall due to clinical event transferred to hospital.

Skin event reported calf laceration when patient was stepping out of exam table, seen by physician and sent to ED for further treatment. Exam table inspected and no issues identified.

Four patient care occurrences. Physician questioned how APRN addressed critical results, reviewed by medical director and APRN care deemed appropriate. One patient called CVS more than once pretending to be calling from physician office for refills, termination of physician-patient relationship letter sent to patient, CVS will only accept electronic prescriptions. One patient disruptive behavior. One patient at risk of suicide refused to be ransferred to behavioral facility and left the office, 911 called and PCP informed.

Three security events. One patient and one family member with aggressive/disruptive behavior. Nurse manager spoke with patient and family member won't return to office. One adult patient with developmental challenges quicked the APRN, no injuries, decision that patient will be seen by male provider next time.

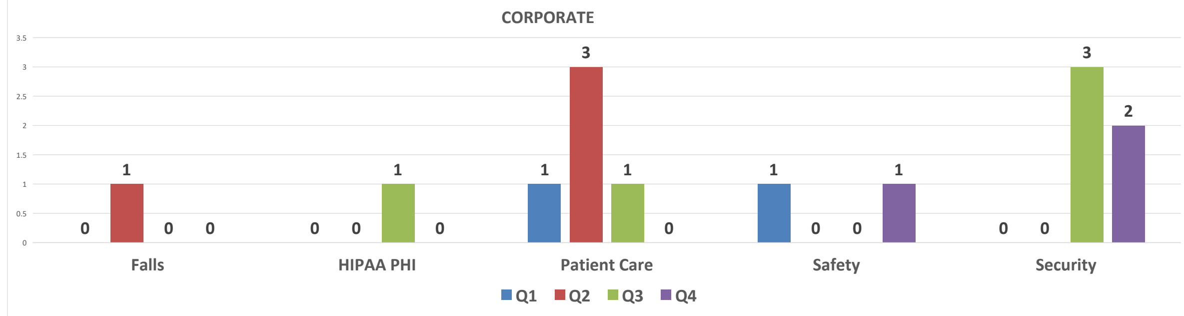
CDTC	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Oct	Nov	Dec	4th Qtr	Total CY20
Falls	1	2	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3
HIPAA PHI	0	0	1	1	0	0	4	4	3	1	0	4	1	2	3	6	15
Medication Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Care	1	0	0	1	0	1	1	2	0	0	0	0	0	0	0	0	3
Security	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Safety	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	3	2	2	7	0	1	5	6	3	1	0	4	1	2	3	6	23



Total of 6 HIPAA/PHI events reported.

Email sent with wrong patient attachment to DOH. Email sent to wrong BH destination. Copy of wrong imunization record provided to patient. Referrals emailed to wrong provider. Two Early Steps forms sent to wrong provider, one fax, one email. Compliance previously met with CDTC staff to reinforce attention to prevent unauthorized PHI disclosure.

CORPORATE	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Oct	Nov	Dec	4th Qtr	Total CY20
Falls	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1
HIPAA PHI	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1
Patient Care	0	0	1	1	3	0	0	3	0	1	0	1	0	0	0	0	5
Safety	1	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1	2
Security	0	0	0	0	0	0	0	0	0	3	0	3	1	0	1	2	5
Totals	1	0	1	2	3	1	0	4	1	4	0	5	1	1	1	3	14



Total 3 occurrences reported.

Safety related to employee trapped inside elevator, managed by facilities.

Two security reports. One related to employee vehicle damage in parking lot, owner notified. One missing property reported to security.