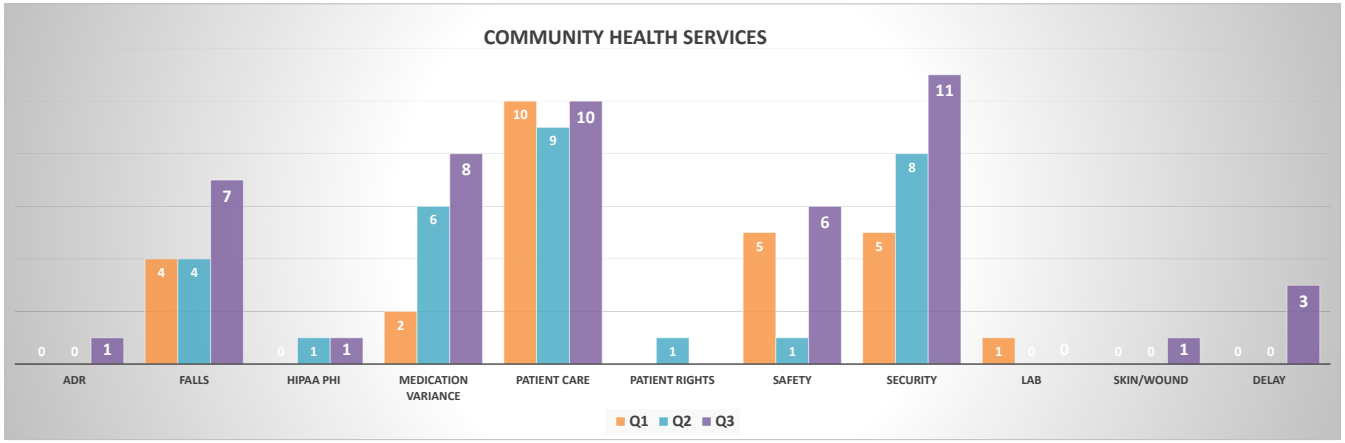
BROWARD HEALTH AMBULATORY SERVICES - RISK MANAGEMENT QUARTERLY REPORT QUARTER 3

COMMUNITY HEALTH SERVICES	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Total CY19
ADR				0				0		1		1	1
Falls	2		2	4	2	1	1	4	3	3	1	7	15
HIPAA PHI				0	1			1			1	1	2
Medication Variance	2			2	4		2	6	1	2	5	8	16
Patient Care	4	4	2	10	3	1	5	9	9	1		10	29
Patient Rights				0	1			1				0	1
Safety	1	3	1	5			1	1	3		3	6	12
Security	2	2	1	5	2		6	8	4	2	5	11	24
Lab		1		1				0				0	1
Skin/Wound				0				0	1			1	1
Delay				0				0	1		2	3	3
Totals	11	10	6	27	13	2	15	30	22	9	17	48	105



Total of 48 occurrences.

ADR due to patient who complained of dry cough after Lisinopril dose was increased, medication changed and referred to cardiology.

Seven falls. One employee slipped and fell on her way to the rear employee entrance due to sludge coming from a drain onto the walkway, no injuries, facilities waterpressured area. Two patients fell due to seizure activity, 911 called. One reported patient fall while getting into transportation. One patient felt dizzy and fell, no injuries noted but transsferred to hospital due to hitting h er head. Mother dropped car seat with baby while stepping down, baby examined by provider, no injuries noted. Other patient felt dizzy and lowered self to floor.

HIPAA/PHI related to medication bag handed to wrong patient due to lack of proper PPID, patient called to exchage bag, corrective action process completed with HR per policy.

Eight medication variances. Extended release not observed on prescription note, physician instructed to pick ER option from list instead of writting it on note. Wrong med bag given to patient with same name but different DOB, tech re-educated. Publix inquired about 2 prescriptions received that did not look legitimate, not ALW patients. One near miss. One duplicate therapy provided to patient by pharmacy, physician and patient contacted for clarification, patient only took one drug. Patient called as she received drug physician had discontinued, prescription had several notes, pharmacists instructed to pay attention to notes. One wrong dose, no harm to patient, staff reminded to verify prescriptions against what is prescribed by provider.

Ten patient care. One patient was BA and transferred to higher level of care due to hyperglycemia. Two AMAs. Five patients transferred to higher level of care due to medical condition.

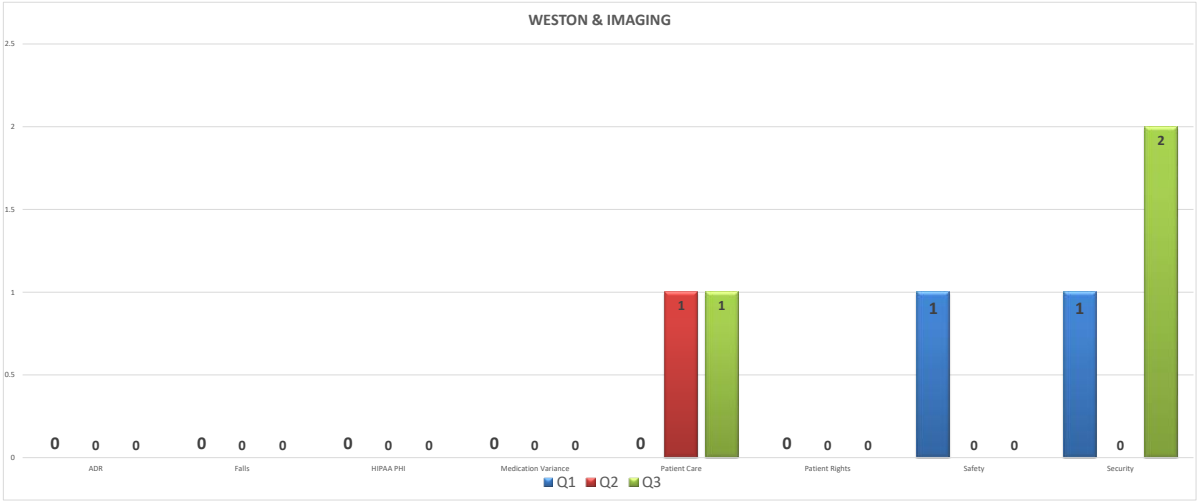
Six safety events. Asphalt hole in parking lot reported to facilities. One false alarm and one alarm not armed which was addressed with Emcompass supervisor. One master key missing from CEB securi ty office found, key is now being secured in the Regional Security Lt. Office.

Eleven security. One patient and visitor altercation, police called and they left clinic. Three patients escorted out due to inappropriate be havior. Security office door lock damaged due to lost key, lock repaired. Verbal abuse and agressive behavior from patients. One employee phone missing, police report completed. Abandoned car in parking lot, police notified. One near miss robery, case number with police. One patient refusing to wear mask.

Skin/wound was a patient superficial laceration to scalp when bending over cabinet, evaluated by physician and then seen at UCC.

Three Delays - Messages left on nurse prompt not retrieved since nurse left clinic, follow up completed for recent messages, ticket with IT placed to rout phone option to the MAs who were assigned responsibility to check messages on a daily basis, leadership notified of need to review phone prompts for all CHS sites. One delay to address Tb related findings on CT chest which were reported to on call provided after hours, addressed with provider by medical director, policy reviewed for expectations, adequate follow ups with patient the next day. Right breast US guided biopsy ordered on May 3rd was never scheduled. Physician called patient on 7/27/21 and reordered biopsy, priority asap. Communication on 5/16 to staff. Shared case with medical director. Mentioned to physician option of ordering referral/test as urgent so it is prioritized. Priority was routine. Patient had biopsy on 8/12/21, no malignant

WESTON & IMAGING	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Total CY19
ADR				0				0				0	0
Falls				0				0				0	0
HIPAA PHI				0				0				0	0
Medication Variance				0				0				0	0
Patient Care				0	1			1		1		1	2
Patient Rights				0				0				0	0
Safety			1	1				0				0	1
Security			1	1				0		1	1	2	3
Totals	0	0	2	2	1	0	0	1	0	2	1	3	6

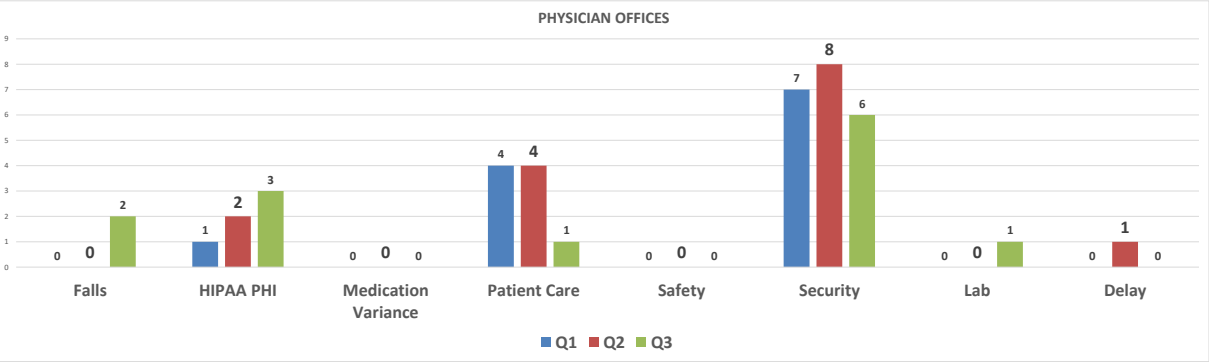


Total of 3 occurrences.

Patient care due to UCC patient transferred to higher level of care.

Two security events. First due to patient eating and not wearing mask at UCC, policy explained. Patient's mother became verbally abusive, refused to leave and called the police, escorted out. One missing ring at imaging center.

PHYSICIAN OFFICES	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Total CY19
Falls				0		0		0	1	1		2	2
HIPAA PHI	1			1		0	2	2	1		2	3	6
Medication Variance				0		0		0				0	0
Patient Care	1	1	2	4	2	1	1	4	1			1	9
Safety				0		0		0				0	0
Security	1	4	2	7	2	3	3	8	3	2	1	6	21
Lab				0				0	1			1	1
Delay				0		1		1				0	1
Totals	3	5	4	12	4	4	6	15	7	3	3	13	40



Total of 13 occurrences.

Two falls. Patient tripped over cement block in parking lot after doctor appointment, son called 911, no issues with cement block. Other patient passed out while checking in for appointment, transferred to hospital.

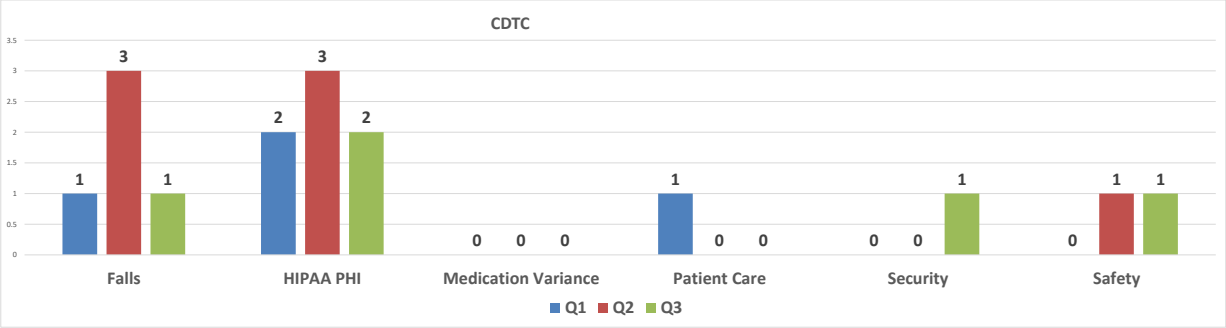
Three HIPAA/PHI - Charges entered under wrong patient. Patient registered under father's name by mistake, same name. Incorrect patient billed. Investigated by compliance.

Patient care related to non compliance with treatment, nurse manager spoke with patient.

Lab due to Access Dx Pharmacogenomic testing reported incorrect DPYD results in their comprehensive panel (Dr. H). List of patients obtained and corrections made. No harm to patients.

Six Security. Physician wallet missing from purse left in office, police report done. Two termination of physician-patient relationships related to safety issues with patient behavior (Dr. R and Dr. B). Missing money from deposit slip, moving forward, all money to be kept in safe. Others related to patient verbal abuse, aggressive and disruptive bahaviors, nurse managers addressed expectations with patients.

CDTC	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Total CY19
Falls			1	1	1	1	1	3		1		1	5
HIPAA PHI	2			2		3		3		2		2	7
Medication Variance				0				0				0	0
Patient Care		1		1				0				0	1
Security				0				0			1	1	1
Safety				0	1			1		1		1	2
Totals	2	1	1	4	2	4	1	7	0	4	1	5	16



Total of 5 occurrences reported.

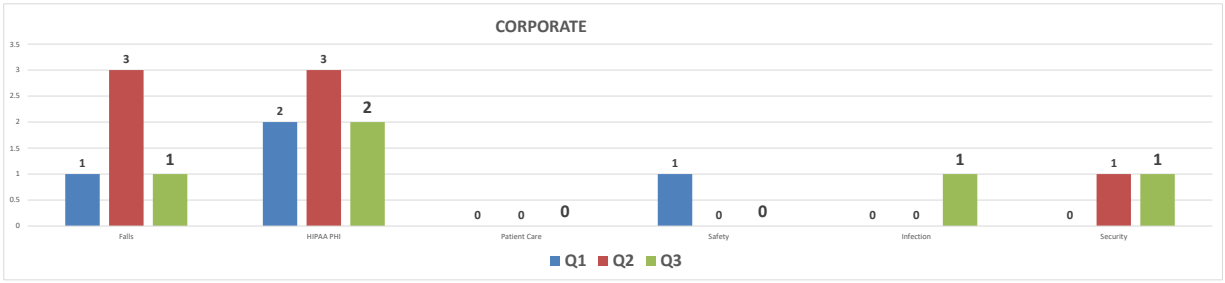
One employee fell in the parking lot without injuries or contributing environmental factors. Employee health was notified.

Two HIPAA/PSI events. Check out instructions given to mother with wrong patient information, mother was contacted to return the papers related to wrong patient. IFSP form emailed to wrong provider. Compliance investigates these events.

One security occurrence involved call from client reporting she left her cell phone on top of staff's car. Staff able to retrieve the broken phone from the road and return it to client.

One safety event due to sharps exposure/needle stick. Dental hygienist got stuck when went to pull needle out with force. They use autoclave instruments and have a recapper device. Nurse manager reviewed event with employee. Employee sent to ED per protocol.

CORPORATE	Jan	Feb	Mar	1st Qtr	Apr	May	June	2nd Qtr	July	Aug	Sept	3rd Qtr	Total CY19
Falls	2	2	3	7	1	1		2			1	1	10
HIPAA PHI	1			1	5	1	1	7			3	3	11
Patient Care			1	1	3	1	6	10		1		1	12
Safety	1	2	1	4	2			2	1		2	3	9
Infection				0				0		1		1	1
Security	1		4	5	2			2	4	2	4	10	17
Totals	5	4	9	18	13	3	7	23	5	4	10	19	60



Total of 19 occurrences.

One fall - Employee misssed step, no reported injuries or environmental hazards.

Three HIPAA/PHI - Compliance reported patient who received bill for another patient. Report to compliance that member of public posted patient information on his personal Instagram, no breach by employee identified. One allegation that IT vendor had a security incident, substantiated and handled by compliance.

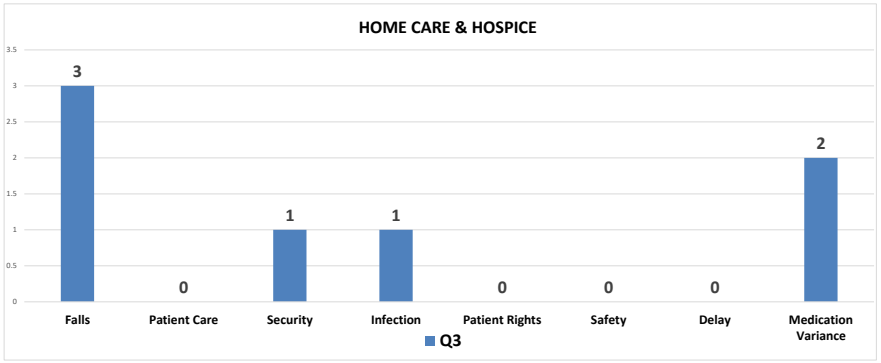
Patient care event related to travel nurse who twisted ankle while crossing street during orientation, agency notified and RN went to UCC.

Three safety - City lights off, FPL contacted. No other concerns.

Infection control related to employee with bed bugs. HR and employee health involved, as well as pest control.

Ten security - Piece of equipment stolen from BH vehicle at Spectrum, reported to police. 1800 Spectrum doors unlocked, open. Facilities ordered latch mecanism to replace in one of the doors. One BH vehicle accident, no employee injuries, claims and insurance notified. ISC lobby doors automatically opening after hours when supposed to be on a time zone till 5pm requiring badge access after, facilities aware. Vehicle accident while employee was driving I95 North and truck cut him off and hit his Van, referred to claims and insurance, no injuries.

HOME CARE &	Jul	Aug	Sep	Q3	Total
Falls	2	1		3	3
Patient Care				0	0
Security		1		1	1
Infection	1			1	1
Patient Rights				0	0
Safety				0	0
Delay				0	0
Medication Variance	1		1	2	2
Totals	4	2	1	7	7



Total of 7 occurrences.

Three falls. Home health patient fell after shower, no injuries, did not ask son's assistance. HH patient fell while using walker, no injuries. All receiving PT services with fall prevention education. One hospice home patient fell when getting out of bed, no injuries.

Security related to patient agrressive language over the phone.

Infection report for patient who developed UTI.