BHN RISK MANAGEMENT QUARTERLY REPORT QUARTER 2 CY 2022

Occurrence Category CY22	Q2
ADR	5
DELAY	32
FALL	39
HIPAAPHI	1
INFECTION	3
LAB	6
MEDICATION	35
PATCARE	265
PATIENT RIGHTS	1
PPID	4
SAFETY	12
SECURITY	212
SKINWOUND	55
SURGERY	6
Total	676

OCCURRENCE CATEGORY CY22 Q2

Total number of incident reports decreased by 16%. Quarter 2 has a total of 676 incidents compared to 801 in Quarter 1. Security occurrences decreased from 250 to 212 while patient care occurrences increased from 249 to 265. Medication occurrences decreased from 60 to 35 and falls decreased from 65 to 39. The overall Near Miss occurrences during Quarter 2 CY 22 is 12, or 2% of overall occurrences. The goal continues to be increased reporting to discern trends to implement risk reduction measures.

Inpatient Falls by Category CY22	Q2
FALL FROM CHAIR	2
FOUND ON FLOOR	13
FALL FROM BED	2
FALL FROM TOILET	3
FALL PATIENT STATES	1
FALL VISITOR STATES	1
SLIP	1
Grand Total	23

INPATIENT FALLS BY CATEGORY CY22 Q2

Decrease in falls from 47 to 23 in Q2, reflecting a 48% decrease. One fall with subdural hematoma at rehab transferred to ICU then hospice, reported as Code 15. Intense Analysis completed for each fall.

HAPIs CY22	Q2
Unstageable Ulcers	1
Stage 3	1
DTPI	2
Total	4

HAPIS CY22 Q2

Decrease in HAPIs by 64% from 11 in Q1 to 4 in Q2. Unstageable due to equipment. Wound Care RN conducted RCAs on all HAPIs and action plans put into place.

MEDICATION VARIANCES CY22	Q2
Contraindication	2
Control Drug Charting	1
Delayed dose	9
Expired Medication	0
Extra Dose	7
Improper Monitoring	4
Missing/Lost Medication	1
Omitted dose	2
Other	3
Prescriber Error	2
Pyxis Miss Fill	0
Reconciliation	1
Self Medicating	1
Wrong Dosage Form	1
Wrong Dose	1
Wrong Drug or IV Fluid	3
Wrong Frequency or Rate	2
Wrong Patient	2
Total	42

MEDICATION VARIANCES CY22 Q2

Medication Variances decreased by 40%, from 60 to 42. Risk, nursing, and administration collaborate monthly to discuss medication variances, trends, and lessons learned from medication variances. Lessons learned are based on trends or high-risk/frequency items that can be avoided. No adverse outcomes. Goal continues to be increased reporting.

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ADR CY22	Q2
Allergy	4
Dermatological	1
Total	5

ADR CY22 Q2
Number of ADRs was the same in Q1 and Q2. No adverse outcomes.

SURGERY RELATED ISSUES CY22	Q2
Consent Issue	2
Surgery Delay	1
Surgical Count	1
Surgical Complication	1
Tooth Damage/Dislodged	1
Total	6

SURGERY RELATED ISSUES CY22 Q2
There was a 65% decrease from quarter 1 as surgery-related issues went from 17 to 6. Surgical count discrepancy between initial wound packing documented as 8 pads and 7 pads retrieved on planned return to surgery, none in patient. Intraoperative ureteral injury possibly presents prior to exploratory laparotomy with resection of colon. Surgery Related incidents are referred to quality as deemed appropriated for review.

SECURITY CY22	Q2
Access Control	10
Aggressive behavior	5
Assault/Battery	3
Break-In	1
Code Assist	75
Code Black	1
Code Elopement	10
Contraband	22
Criminal Event	1
Elopement- Involuntary Admit	1
Elopement- Voluntary Admit	3
Property Damaged/Missing	22
Security Presence Requested	58
Threat of violence	5
Vehicle Accident	1
Verbal Abuse	2
Total	220

SECURITY CY22 Q2
Decrease in Security occurrences from 250 to 220, a 12% decrease. Code Assists decreased from 112 in Q1 to 75 in Q2, but Security Presence increased from 56 in Q4 to 58 in Q2.

SAFETY CY22	Q2
Code Red	2
Safety Hazard	7
Sharps Exposure	3
Total	12

SAFETY CY22 Q2
Safety occurrences decreased from 14 in Q1 to 12 in Q2.

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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.)

Code 15 Reported:

84-year-old female admitted to inpatient rehabilitation on 5/26/22 after hospitalization for acute ischemic stroke, encephalopathy, acute renal failure, dehydration, diarrhea, bradycardia, UTI, thrombocytopenia, hypertension, weakness, arteriosclerotic disease of the aorta.

On 6/1/22, the patient had a fall in the bathroom after which a brain CT was ordered with findings of a right-sided subdural hematoma. Transferred to ICU.

Patient had been taken to the bathroom by PCA who left patient sitting on the toilet while waiting outside with door ajar. Patient asked for privacy and agreed to let PCA know when finished for assistance up from toilet. PCA was in the room near the door but unable to get to patient in time to prevent this fall. Patient hit right side of head on sink counter.

Patient was instructed not to get up and to call when done. PCA took a few steps away from the bathroom door to assist other PCA in the room. Patient had been previously ambulated to bathroom with staff at doorway and she would call when finished without incident. Using the interpreter line, the RN asked patient what happened. Patient stated, "I am ok, I forgot to call for help, tried to get up, my legs gave out and I fell". Repeat brain CT on 6/2/22 revealed no significant changes. Neurosurgery recommended continued observation in ICU and repeat CT next day.

In the afternoon of 6/2/22, patient was noted with increasing headache. Brain CT showed increasing size of subdural hematoma with midline shift. Platelets continued low regardless of transfusions and patient was started on tranexamic acid in attempts to slow the bleeding.

Diagnosis of autoimmune hemolytic anemia with thrombocytopenia. Further deterioration in subsequent CTs. Operative report documented new bleeding location with several bridging veins which were oozing and required coagulation. Multiple abnormal veins and arteries were noted on in the right parietal region which could have represented a small arterial venous malformation. On 6/9/22, family agreed with DNR status and hospice.

AHCA Annual Reportable Events

Fall with non-displaced humeral neck fracture in ED, no surgery recommended
Fall with forehead laceration requiring sutures in ED
Unstageable bridge of nose and stage 3 coccyx at SICU
DTPI left heel and right foot lateral at 9th floor

Opportunities discovered related to HAPIs
No nutritional consult
Repositioning inconsistent with policy.
Admission photos or transfer photos not completed
Assessment of patient skin throughout admission documented as intact
Patient did not have heel off loaders and was on standard surface
No documentation for heel offloading until or boots not used until later date

Process Improvement

Fall prevention re-education provided to all team members of the Broward Health Rahab Institute (BHRI). In-person education will be conducted by the charge nurse, nurse manager and rehab manager. Education will include fall prevention initiatives and interventions, with emphasis on not leaving patients alone in the bathroom.

Welcome to BHRI letter was revised to contain statement “Never leave patients in bathroom alone”. It was also be condensed to one page. All float staff will receive Welcome to BHRI letter (bullet point of rehab initiatives and processes) at beginning of shift to read, acknowledge and sign. Nurse manager will choose 3 questions to ask sample number of floats to confirm receipt of Welcome to BHRI. letter.

Nurse manager and rehab director revised new hire 90-day checklist, so it is divided into 3 parts according to priority of skills. First section includes higher priority skills, second moderate and third lower. Fall prevention initiatives are be part of first section.

Patient bathroom blitz (Call Don't Fall) was created in the form of laminated posters/signs in English, Spanish and Creole. These will alert patients not get up from the toilet without calling for assistance. Posters will be placed inside the 4th floor bathrooms so patients can see it while toileting.

All staff to review skin/wound guidelines policy with unit signature of confirmation
Wound Care to round with 3se staff education needs regarding initiation of nutrition or wound care consults for high-risk patients
Attendance to the skin health injury prevention class for review of offloading devices
Specialty support
Unit huddles and review of skin/wound guidelines policy for photographic expectations and repositioning standards
Documentation of device check’s twice a shift under the skin breakdown prevention tab.
Product review for head positioners, currently utilizing the dandle-lion gel pillow, Z-flo fluidized positioners or alternative
Reevaluation of preventative products for Bipap/ Cpap masks
Respiratory communication with nursing staff and wound care, Review of Bipap/Cpap mask, wound care to create quick