BROWARD HEALTH NORTH - RISK MANAGEMENT QUARTERLY REPORT QUARTER 4

Occurrence Category CY21	Q4	%
SECURITY	299	37%
PATCARE	285	35%
SKINWOUND	53	6%
DELAY	47	6%
MEDICATION	43	5%
FALL	42	5%
SAFETY	15	2%
SURGERY	13	2%
INFECTION	9	1%
LAB	5	1%
HIPAAPHI	3	0%
ADR	1	0%
Patient Rights	1	0%
PPID	1	0%
Total	817	100%

OCCURRENCE CATEGORY CY21 Q4:
Total number of incident reports increased by 9%. Quarter 4 has a total of 817 incidents compared to 748 in Quarter 3. The Patient Care occurrences increased from 196 to 285 and Fall incidents decreased from 61 to 42 reflecting a 31% decrease. The overall Near Miss occurrences during Quarter 4 CY 21 is 11, or 1% of overall occurrences. The goal continues to be increased reporting to discern trends in order to implement risk reduction measures. Risk Management attends nursing huddles to promote patient safety and proactively respond to questions staff may have.

Inpatient Falls by Category CY21	Q4
Found on Floor	21
Eased to Floor by Employee	3
From Bed	3
From Toilet	2
Patient States	2
While Ambulating	2
Total	33

INPATIENT FALLS BY CATEGORY CY21 Q4:
Decrease in falls from 44 to 33 in Q4, reflecting a 25% decrease. There were 3 inpatient falls with injury. All patient falls are discussed daily during the morning huddle. We had 2 Level 3 falls and 1 Level 4 fall in Q4. Level 3: 1 - Confused patient found on floor (skin tear). 2 - Patient found on floor after being transported to unit (subdural hematoma). Intense Analysis completed. Level 4: 1 - Patient found seizing on floor (dislocated shoulder). Risk Management joined the Falls Committee in October 2021, assisting with various aspects of documentation including streamlining data for accuracy of falls reporting based on HAS submissions including NDNQI guidelines.

HAPIs CY21	Q4
Other	2
Unstagable	2
DTI	1
Stage II	1
Stage III	1
Total	7

HAPIS CY21 Q4:
7 HAPIs compared to 4 HAPIs in Quarter 3. Three of the HAPIs are HACs (stage 3, unstageable) which occurred in intensive care units, two of which were due to equipment. No further trends identified. Wound Care Nurse performs intense analyses on all HAPIs.

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MEDICATION VARIANCES CY21	Q4
Omitted dose	6
Improper Monitoring	4
Other	4
Delayed dose	3
Prescriber Error	3
Wrong frequency or rate	3
Contraindication	2
Expired Medication	2
Extra Dose	2
Pyxis Miss Fill	2
Wrong dose	2
Wrong Drug or IV Fluid	2
Wrong time	2
Control Drug Charting	1
Control Drug Discrepancy-count	1
CPOE issue	1
Missing/Lost Medication	1
Self-Medicating	1
Wrong patient	1
Total	43

MEDICATION VARIANCES CY21 Q4:
Medication Variances decreased by 17% from 52 to 43. 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. They are then distributed to staff by various methods such as created into videos produced and starred in by pharmacy staff, emailed to all BHN in CEO newsletter, or played on the tv outside of main hospital elevators. Lessons learned discussed in Risk Management section at the bottom of this report. Lessons learned and opportunities are also reviewed in Patient Care Key Group by pharmacy manager. No adverse outcomes. Goal continues to be increased reporting.

ADR CY21	Q4
Allergy	1
Total	1

ADR CY21 Q4:
Patient received Benadryl to subside side effects. No adverse outcome.

SURGERY RELATED CY21	Q4
Consent Issues	2
Extubation/Intubation	2
Sugical Count	2
Surgery Delay	2
Unplanned Return to OR	2
Anesthesia Complication	1
Retained Foreign Body	1
Surgery/Procedure Cancelled	1
Total	13

SURGERY RELATED CY20Q4:
There was a 63% increase from quarter 3. Surgery related issues went from 8 to 13 in quarter 4. Two surgical count incidents compared with zero in Q3. One retained foreign body incident which was the tip of a surgical hook(~0.5mm). Process followed by completing x-ray and visual inspection by surgeon and confirmed no metal tip found in patient. Two unplanned return to the OR, both referred to quality. Surgery Related incidents are referred to quality as deemed appropriated for review.

SECURITY CY21	Q4
Code Assist	108
Security Presence Requested	86
Property Damaged/Missing	31
Contraband	22
Code Elopement	20
Aggressive behavior	9
Threat of violence	7
Assault/Battery	6
Trespass	3
Verbal Abuse	3
Vehicle Accident	2
Security Transport	1
Smoking Issues	1
Total	299

SECURITY CY21 Q4:
Slight increase in Security occurrences from 276 to 299, reflecting a 7% increase from the previous quarter. Security Presence increased from 51 to 86 reflecting a 69% percent increase. Code Assist decreased from 148 to 108, a 27% decrease correlating to the increase in security presence requested.

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SAFETY CY21	Q4
Safety Hazard	6
Code Red	4
Sharps Exposure	3
False Alarm	1
Fire/Smoke/Drill	1
Total	15

SAFETY CY21 Q4:
Safety occurrences decreased in quarter 4 from 18 to 15 reflecting a 17% decrease from the previous quarter.

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:** In an abundance of caution, case was reported as a Code 15 due to possible alleged misdiagnosis of stroke.

❖ **AHCA Annual Reportable Events (5)**
- Unstageable pressure injuries (2)
- Stage 3 pressure injury (1)
- Fall with hematoma (1)
- Alleged Fall with shoulder dislocation (1)

❖ **Medication Variance Lessons Learned**
- Be sure to titrate following the protocol. If multiple titrations, communicate with physician for orders and document accordingly (e.g. wean off phenylephrine before norepi).
- Caution with PRN pain meds in addition to PCAs
- proactive intervention/reporting
- All orders must be entered prior to administration
- There is no substitute for the five rights, you must verify them all prior to administration and there are no work arounds when receiving an alert. (Get a second opinion! Caution: alert fatigue)
- Optimize communication during handoff for medication related delays, omissions, etc.
- Patient Own Meds: Send home with the patient, if possible. If not, bag and send to pharmacy for storage. If order for patient to take while hospitalized, get physician order, send to pharmacy to identify and re-label.

❖ **Intense Analyses Completed**
- Fall resulting in subdural hematoma
- Alleged fall resulting in shoulder dislocation

❖ **Process Improvement**
- Nursing education on discharge requirements for patients with central lines
- Implementation of new section in the paper medical record to alert providers of legal information such as Baker Act, Marchman Act, Court Orders, etc.
- Posters placed in various departments throughout hospital to list occurrences that are to be reported in HAS and how to contact Risk Management with the goal of increased reporting.