BHMC RISK MANAGEMENT QUARTERLY REPORT

Occurrence Category CY22 *Comparison-Binoculars-BHMC Occurrences by sub category-Addtl Query Y - binoculars-Patient Occurrences-Frequency "q" quarter OR (HAS Comparison Report "BHMC PATIENT FALLS"-Occurrence Sub Cat and -Date)	Q1	%
ADR	4	0%
DELAY	39	3%
FALL	58	5%
HIPAAPHI	6	1%
INFECTION	4	0%
LAB	25	2%
MEDICATION	56	5%
OBDELIVER	58	5%
PATCARE	394	33%
PATRIGHT	2	0%
PPID	0	0%
SAFETY	28	2%
SECURITY	482	41%
SKINWOUND	4	0%
SURGERY	26	2%
Grand Total	1186	100%

OCCURRENCE CATEGORY CY22:

Quarter 1 totaled 1186 patient occurrences. There were a total of 16 reported near miss occurrences making up 1.3% of all occurrences.

Inpatient Falls by Category CY22 (HAS Comparison Report - Monthly Falls OR HAS Comp Occur Cat and Sub and omit Visit falls)	Q1	%
Child Developmental	1	1.72%
Child fall during play	1	1.72%
Eased to floor by non employee	1	1.72%
Found on floor	29	50.00%
From Bed	8	13.79%
From Bedside Commode	1	1.72%
From Chair	4	6.90%
From Equipment, i.e. stretcher, table, etc.	1	1.72%
From Toilet	1	1.72%
Patient States	3	5.17%
Visitor States	3	5.17%
While ambulating	5	8.62%
FALL Total	58	100%

INPATIENT FALLS BY CATEGORY CY22:

There were a total of 58 Inpatient Falls for Q1 Highest category for falls were Patients Found on Floor making up 50% of falls.

Falls are discussed and reviewed for lessons and opportunities at weekly HAC meeting facilitated by BHMC Patient Safety Officer.

OB DELIVERY CY22 (HAS Comparison Report Occur Cat, Occur Sub cat - OB Occurrences)	Q1	%
Birth Trauma	0	0.00%
CPOE issue	0	0.00%
C-Section with no first assist	1	1.72%
Emergency C-Section > 30 min	1	1.72%
Fetal Distress	1	1.72%
Fetal/Maternal Demise	0	0.00%
Induction Bishop <6	0	0.00%
Infant d/c to wrong person	0	0.00%
Instrument Related Injury	0	0.00%
Maternal complications	1	1.72%
Maternal Transfer To Higher Level Of Care	2	3.45%
Meconium Aspiration	0	0.00%
Meconium staining	0	0.00%
Neonatal complications - Admit Mother/Baby	0	0.00%
Neonatal complications - Admit NICU	24	41.38%
Neonatal complications - Apgar <5 @5 min	0	0.00%
Neonatal complications - Impaired Skin Integrity	0	0.00%
Neonatal complications - IV Infiltrate	0	0.00%
OB Alert	0	0.00%
Other	13	22.41%
Postpartum Hemorrhage	6	10.34%
Return To Dr (Labor Delivery Room)	1	1.72%
RN Attended Delivery	3	5.17%
RN Unattended Delivery	0	0.00%
Shoulder Dystocia	2	3.45%
Sponge/Needle/Instrument Issues	0	0.00%
Sterile field contaminated	0	0.00%
Surgical Count	0	0.00%
Unplanned Procedure	3	5.17%
TOTAL	58	100.00%

OB DELIVERY CY22:

There were a total of 58 OB Delivery incidents for Q1

Highest category for incidents were related to Neonatal complications which contributed to 41.38% of OB Delivery related incidents.

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HAPIs CY22 Skin Wound Slimbach Pressure Injury - Acquired	Q1	%
Pressure Injury - Acquired	0	100%

HAPIS CY22:

There were 0 Hospital Acquired Injuries for Q1.

MEDICATION VARIANCES CY22 HAS Browse - BHMC Med Variance (remove duplicate occurrence# OR OR HAS Comparison and add Occur Cat= Medication and Sub Cat= all medication types)	Q1	%
Contraindication	2	3.57%
Control Drug Charting	0	0.00%
Control Drug Discrepancy Investigation	0	0.00%
Delayed Dose	10	17.86%
eMAR - Transcription/Procedure	0	0.00%
Expired Medication	0	0.00%
Extra Dose	2	3.57%
Improper Monitoring	2	3.57%
Labeling Error	1	1.79%
Missing/Lost Medication	1	1.79%
Omitted Dose	6	10.71%
Other	8	14.29%
Prescriber Error	5	8.93%
Pyxis Count Discrepancy	0	0.00%
Pyxis Miss Fill	1	1.79%
Reconciliation	0	0.00%
Scan Failed	0	0.00%
Self-Medicating	0	0.00%
Unordered Drug	1	1.79%
Unsecured Medication	0	0.00%
Wrong Concentration	4	7.14%
Wrong Dosage Form	0	0.00%
Wrong Dose	8	14.29%
Wrong Drug or IV Fluid	2	3.57%
Wrong Frequency or Rate	1	1.79%
Wrong Patient	1	1.79%
Wrong Route	1	1.79%
MEDICATION Total	56	100.00%

MEDICATION VARIANCES CY22:

There was a total of 56 medication variances for Q1.

Highest med variance category was due to Delayed Dose, which contributed to 17.86% of total variances.

Risk, nursing, and administration collaborate to discuss medication variances and trends.

Medication variances are also reviewed at Patient Care Key Group / RQC meeting and by Pharmacy staff.

ADR CY22	Q1	%
Allergy	1	25.00%
Miscellaneous	3	75.00%
ADR Total	4	100.00%

ADR CY22:

Total of 4 ADR in Q1 2022.

SURGERY RELATED ISSUES CY22	Q1	%
Anesthesia Complication	2	7.69%
Consent Issues	6	23.08%
CPOE issue	0	0.00%
Surgery Delay	4	15.38%
Extubation/Intubation	0	0.00%
Puncture or Laceration	0	0.00%
Retained Foreign Body	2	7.69%
Surgery/Procedure Cancelled	1	3.85%
Surgical Complication	2	7.69%
Sponge/Needle/Instrument Issues	1	3.85%
Sterile field contaminated	3	11.54%
Surgical Count	3	11.54%
Incorrect information on patient's chart	0	0.00%
Positioning Issues	0	0.00%
Surgical site marked incorrectly	0	0.00%
Tooth Damaged/Dislodged	1	3.85%
Unplanned Surgery	1	3.85%
Unplanned Return to OR	0	0.00%
Wrong Patient	0	0.00%
Wrong Procedure	0	0.00%
Wrong Site	0	0.00%
SURGERY TOTAL	26	100.00%

SURGERY RELATED ISSUES CY22:

There was a total of 26 surgery related issues or Q1.

Highest surgery related issue was Consent issues, which contributed to 23% of surgery related issues.

SECURITY CY22	Q1	%
Abduction	0	0.00%
Access control	0	0.00%
Active Shooter	0	0.00%
Aggressive behavior	12	2.49%
Arrest	0	0.00%
Assault/Battery	6	1.24%
Break-in	1	0.21%
Code Assist	128	26.56%
Code Black	0	0.00%
Code Elopement	9	1.87%
Code Green	0	0.00%
Code Stork	0	0.00%
Code Strong	2	0.41%
Contraband	14	2.90%
Criminal Event	0	0.00%
Elopement -Involuntary admit (BA, patient's under police custody, vulnerable adults etc.)	0	0.00%
Elopement -Voluntary admit (persons admitted on their own accord/will; non-vulnerable individuals)	2	0.41%
Property Damaged/Missing	17	3.53%
Rapid Response Team - Visitor	0	0.00%
Security Presence Requested	288	59.75%
Smoking Issues	0	0.00%
Security Transport	0	0.00%
Threat of violence	0	0.00%
Trespass	0	#DIV/0!
Vehicle Accident	0	0.00%
Verbal Abuse	3	0.62%
SECURITY TOTAL	482	100.00%

SECURITY CY22:

There was a total of 482 security incidents for Q1.

Highest incidents reported were related to Security Presence Requested which was 59.75% of total incidents.

SAFETY CY22	Q	%
Biohazard Exposure	0	0.00%
Code Red	0	0.00%
Code Spill - Chemical	0	0.00%
Code Spill - Chemo	0	0.00%
Electrical Hazard	0	0.00%
Elevator entrapment	0	0.00%
False Alarm	0	0.00%
Fire/Smoke/Drill	0	0.00%
Gas/Vapor Exposure	0	0.00%
Safety Hazard	27	96.43%
Sharps Exposure	1	3.57%
SAFETY Total	28	100.00%

SAFETY CY22:

There was a total of 28 Safety incidents for Q1.

Highest incidents reported were related to Safety Hazard which was 96.43% of total incidents.

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.)

5ST off the monitor death - This event involved a 73-year-old male with a significant history of chronic back problems arriving at BHMC as a level 2 trauma alert on 1/18/2022. Patient apparently was sitting in a walker chair, when the chair collapsed and folded in on the patient. Patient states that it was compressing on him and it was difficult to breathe so he threw himself backwards exiting the chair and landing flat on his back. Patient's chief complaint was lower back pain. He was seen by a multidisciplinary team to include Neurosurgery, Palliative medicine, and Cardiology. Patient had a cardiac history of atrial fibrillation (on Coumadin), hypertension, hyperlipidemia, a pacemaker, and was morbidly obese. Cardiology ordered telemetry monitoring for the patient.

There were some issues with the patient taking home meds given to him by his wife, and after receiving Narcan, the patient was agitated, and there was difficulty keeping the cardiac monitor on the patient.

1/23/2022 at 5:29 one of the PCA's went into the room to wake up the patient and found him unresponsive. A Code was paged overhead and the initial rhythm the patient was found in was PEA. ACLS interventions were taken, but the patient expired at 0543.

The rapid escalation process was not followed in this case, which could have led to earlier intervention

6NT off the monitor death - This event involved a 62 y/o male with medical history significant for polysubstance abuse with cocaine and alcohol, hypertension, chronic pancreatitis, current smoker and COPD. The patient also had a history of DVT's

Patient was brought via EMS and triaged with a chief complaint of chest pain.

In the ER, the patient had labs and x-rays done. Significant labs for the patient had WBC's of 19.56, a lactic acid of 5.4. The chest x-ray showed patchy airspace infiltrates throughout both lungs with more focal dense airspace consolidation within the left upper lobe. The patient was COVID negative on antigen test. The patient was treated in the ER with 2 liters of NS bolus, and Rocephin for antibiotics. The patient was admitted to the medicine service and admission orders were entered. The original order was for a medical-surgical admission, but was modified by the admitting physician to a telemetry order.

At approximately 0954, a transporter took the patient via wheelchair down to radiology for a CT Angio to rule out pulmonary embolism. The patient had the study which was negative. The radiology techs that did the study did not indicate that the patient was in any distress at that time.

At 1122hrs, the primary RN saw the order for telemetry;

At 1211hrs, a radiology staff member transported the patient back to his floor via wheelchair.

At 1454hrs, Physical Therapy called the primary RN to let him know they wanted to work with his patient. After the physical therapist left there was not communication with the primary RN.

At 1642hrs, the primary RN went to the room to put the patient on the cardiac monitor, and found the patient unresponsive and pulseless. CPR was initiated and a Code Blue called, but the team was not able to get ROSC on the patient and he expired.

Retained Foreign Body - This event involves a 24 y/o patient who came in as a motor vehicle trauma patient on 3/25/22. The patient underwent an open right lower lobectomy for hemorrhagic consolidation and pneumatocele that had developed in the right lower lobe. During the procedure the chest tubes were being placed and trimmed. The posterior chest tube required a shorter length then the anterior tube and therefore was trimmed appropriately to allow the Y connector to lie properly. However the diameter of the tube was insufficient as incised to allow the 3/8thsY connector to be inserted. At that time the chest tube was then dilated at its opening with a needle driver and the tubes were then connected. Postoperative chest x-ray revealed a metallic fragment and repeat chest x-ray confirmed its position to be unchanged and it appeared to be within the posterior chest tube.

The patient was returned to the operative theatre on 3/26/22 and surgery to remove the metallic fragment was completed. The fragment was visualized and shaken free of the tube. Inspection of the fragment revealed it to be portion of a needle driver jaw insert which had dislodged and fallen into the tube during dilation as described above.

Postop fluoroscopy revealed no remaining metallic fragments. Patient was taken to the recovery room in stable condition having tolerated the procedure well.

FDA MedWatch report completed. Contact made with the manufacturer. Photos included with the Adverse Incident report to AHCA.