| Occurrence Category CY23 (Patient Occurrences Comparison Report from OVR Stats page) | Q3   |
|--|------|
| ADR  | 3    |
| DELAY  | 48   |
| FALL   | 49   |
| HIPAAPHI   | 13   |
| INFECTION  | 5    |
| LAB  | 28   |
| MEDICATION   | 116  |
| OBDELIVER  | 102  |
| PATCARE  | 488  |
| PATRIGHT   | 2    |
| PPID   | 5    |
| SAFETY   | 52   |
| SECURITY   | 412  |
| SKINWOUND  | 152  |
| SURGERY  | 70   |
| Grand Total  | 1545 |

### OCCURRENCE CATEGORY CY23:

During CY23 Q3 there were a total of 1545 patient occurrences as compared to Q2 which totaled 1329 patient occurrences reflecting a 16.25% increase in overall occurrences from Q2 to Q3.

There were a total of 38 reported near miss occurrences making up 2.4% of all occurrences.

| Inpatient Falls by Category CY23 *(Comparison-binoculars- BHMC Inp Falls by Subcat -change date needed) | Q3 |
|---|----|
| Child Developmental   |    |
| Child fall during play  |    |
| Eased to floor by employee  | 3  |
| Eased to floor by non employee  | 1  |
| Found on floor  | 23 |
| From Bed  | 1  |
| From Bedside Commode  | 1  |
| From Chair  | 1  |
| From Equipment, i.e. stretcher, table, etc.   |    |
| From Toilet   | 2  |
| Patient States  |    |
| Slip  | 4  |
| Visitor States  |    |
| While ambulating  | 1  |
| Inpatient Fall Total  | 37 |

#### **INPATIENT FALLS BY CATEGORY Q3 CY23:**

There were a total of 37 Inpatient Falls for Q3 a 36.20% decrease from Q2.

There was 7 falls with injuries reported during Q3:

- (2) Abrasion
- (4) Laceration
- (1) Pain

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

| OB DELIVERY CY23 (Patient Occurrences Comparison Report from OVR Stats page) | Q3  |
|--|-----|
| Birth Trauma   | 1   |
| CPOE issue   | -   |
| C-Section with no first assist   | -   |
| Emergency C-Section > 30 min   | 2   |
| Fetal Distress   | 1   |
| Fetal/Maternal Demise  | 2   |
| Induction Bishop <6  | -   |
| Infant d/c to wrong person   | -   |
| Instrument Related Injury  | 2   |
| Maternal complications   | 6   |
| Maternal Transfer To Higher Level Of Care                                    | 1   |
| Meconium Aspiration  | -   |
| Meconium staining  | -   |
| Neonatal complications - Admit Mother/Baby                                   | -   |
| Neonatal complications - Admit NICU  | 27  |
| Neonatal complications - Apgar <5 @5 min                                     | 3   |
| Neonatal complications - Impaired Skin Integrity                             | 2   |
| Neonatal complications - IV Infiltrate                                       | 3   |
| OB Alert   | -   |
| Other  | 10  |
| Postpartum Hemorrhage  | 27  |
| Return To Ldr (Labor Delivery Room)  | -   |
| RN Attended Delivery   | -   |
| RN Unattended Delivery   | -   |
| Shoulder Dystocia  | 12  |
| Sponge/Needle/Instrument Issues  | -   |
| Sterile field contaminated   | 1   |
| Surgical Count   | 1   |
| Unplanned Procedure  | 1   |
| OB Delivery Total  | 102 |

### OB DELIVERY Q3 CY23:

There were a total of 102 OB Delivery incidents for Q3 with an increase of 73% from Q2.

Shoulder dystocia and postpartum hemorrhage with QBL>1000 are sent to quality for review and to ensure proper quality of care.

No trends identified.

### BHMC RISK MANAGEMENT QUARTERLY REPORT QUARTER 3 CY23

| HAPIS CY23 (Browse - Binoculars - BHMC HAPIs) | Q3 |
|---|----|
| Pressure Injury - Acquired                    | 36 |

| MEDICATION VARIANCES (Patient Occurrences Comparison Report on OVR Stats page) | Q3  |
|--|-----|
| Contraindication   | 5   |
| Control Drug Discrepancy Investigation   | 1   |
| Control Drug Charting  | 1   |
|  |     |
| Control Drug Discrepancy-count   | 1   |
| Control Drug Diversion/Suspicion   | -   |
| CPOE issue   | -   |
| Delayed dose   | 11  |
| eMAR - Transcription/Procedure   | -   |
| Expired Medication   | 1   |
| Extra Dose   | 6   |
| Hoarding Medications For Later Use   | 1   |
| Illegible Order  | -   |
| Improper Monitoring  | 10  |
| Labeling Error   | -   |
| Missing/Lost Medication  | 3   |
| Omitted dose   | 3   |
| Other  | 11  |
| Prescriber Error   | 7   |
| Pyxis Count Discrepancy  | 1   |
| Pyxis False Stockout   | -   |
| Pyxis Miss Fill  | 1   |
| Reconciliation   | 1   |
| Return Bin Process Error   | -   |
| Scan Failed  | -   |
| Self-Medicating  | -   |
| Unordered Drug   | 1   |
| Unsecured Medication   | 5   |
| Wrong Concentration  | 4   |
| Wrong dosage form  | 1   |
| Wrong dose   | 14  |
| Wrong Drug or IV Fluid   | 12  |
| Wrong frequency or rate  | 10  |
| Wrong patient  | 1   |
| Wrong Route  | 2   |
| Wrong time   | 2   |
| Med Variance Total   | 116 |

# HAPIS Q3 CY23:

There were 36 Hospital Acquired Pressure Injuries for Q3.
Total of 36 this quarter with an increase of 19 since last quarter.
Out of the 36 HAPIs 6 were reportable.

# MEDICATION VARIANCES Q3 CY23:

There was a total of 116 medication variances for Q3 with an increase of 36% from Q2.

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 CY23 (Patient Occurrences Comparison Report from OVR Stats page) | Q3 |
|--|----|
| Allergy  | 3  |
| Miscellaneous  |    |
| ADR Total  | 3  |

### ADR CY23:

Total of 3 ADR in Q3 2023.

| SURGERY RELATED ISSUES CY23                                 | Q3 |
|---|----|
| (Patient Occurrences Comparison Report from OVR Stats page) |    |
| Anesthesia Complication                                     | -  |
| Consent Issues  | 12 |
| CPOE issue  | -  |
| Surgery Delay   | 6  |
| Extubation/Intubation                                       | -  |
| Puncture or Laceration                                      | 2  |
| Retained Foreign Body                                       | -  |
| Surgery/Procedure Cancelled                                 | 5  |
| Surgical Complication                                       | 8  |
| Sponge/Needle/Instrument Issues                             | 3  |
| Sterile field contaminated                                  | 8  |
| Surgical Count  | 25 |
| Incorrect information on patient's chart                    | -  |
| Positioning Issues  | -  |
| Surgical site marked incorrectly                            | -  |
| Tooth Damaged/Dislodged                                     | -  |
| Unplanned Surgery   | -  |
| Unplanned Return to OR                                      | 1  |
| Wrong Patient   | -  |
| Wrong Procedure   | -  |
| Wrong Site  | -  |
| Surgery Total   | 70 |

| SURGERY RELATED ISSUES CY23                                 | Q3 |
|---|----|
| (Patient Occurrences Comparison Report from OVR Stats page) |    |
| Anesthesia Complication                                     | -  |
| Consent Issues  | 12 |
| CPOE issue  | -  |
| Surgery Delay   | 6  |
| Extubation/Intubation                                       | -  |
| Puncture or Laceration                                      | 2  |
| Retained Foreign Body                                       | -  |
| Surgery/Procedure Cancelled                                 | 5  |
| Surgical Complication                                       | 8  |
| Sponge/Needle/Instrument Issues                             | 3  |
| Sterile field contaminated                                  | 8  |
| Surgical Count  | 25 |
| Incorrect information on patient's chart                    | -  |
| Positioning Issues  | -  |
| Surgical site marked incorrectly                            | -  |
| Tooth Damaged/Dislodged                                     | -  |
| Unplanned Surgery   | -  |
| Unplanned Return to OR                                      | 1  |
| Wrong Patient   | -  |
| Wrong Procedure   | -  |
| Wrong Site  | -  |
| Surgery Total   | 70 |

| SECURITY CY23 (Patient Occurrences Comparison Report from OVR Stats page) | Q3  |
|---|-----|
| Abduction   | -   |
| Access control  | -   |
| Aggressive behavior   | 20  |
| Armed Intruder  | -   |
| Arrest  | 2   |
| Assault/Battery   | 29  |
| Break-in  | -   |
| Code Black  | -   |
| Code Elopement  | 4   |
| Code Pink   | -   |
| Code Strong   | -   |
| Contraband  | 15  |
| Criminal Event  | -   |
| Elopement -Involuntary admit  | 1   |
| Elopement -Voluntary admit  | 8   |
| Property Damaged/Missing  | 28  |
| Rapid Response Team - Visitor   | 3   |
| Security Assistance *new August 2022                                      | 56  |
| Security Presence Requested   | 190 |
| Security Transport  | 1   |
| Smoking Issues  | -   |
| Threat of violence  | 14  |
| Trespass  | 2   |
| Vehicle Accident  | 3   |
| Verbal Abuse  | 36  |
| Security Total  | 412 |

| SAFETY CY23 (Patient Occurrences Comparison Report from OVR Stats page) | Q3 |
|---|----|
| Biohazard Exposure  | 1  |
| Code Red  | 14 |
| Code Spill - Chemical   | -  |
| Code Spill - Chemo  |    |
| Electrical Hazard   | 1  |
| Elevator entrapment   |    |
| False Alarm   |    |
| Fire/Smoke/Drill  |    |
| Gas/Vapor Exposure  |    |
| <br>Safety Hazard   | 25 |
| Sharps Exposure   | 10 |
| Safety - Other (no category)  | 1  |
| Safety Total  | 52 |

### SURGERY RELATED ISSUES Q3 CY23:

There was a total of 70 surgery related issues for Q3 with a 75% increase from Q2.

Consent and Surgical count related issues are mostly related to trauma patient who need emergent surgery.

### SECURITY Q3 CY23:

There was a total of 412 security incidents for Q3 with a 11% increase in security occurrences from Q2.

182 (44%) of security incidents were related to BH and Psych ED patients.

# SAFETY Q3 CY23:

There was a total of 52 Safety incidents for Q3 with a no % increase or decrease in safety occurrences from Q2.

Highest category for incidents were related to code red -No harm to patient or staff.

### **REGIONAL RISK MANAGEMENT SECTION:**

(MAY INCLUDE PERFORMANCE IMPROVEMENT INITIATIVES, SERIOUS INCIDENTS, AHCA ANNUAL REPORTABLE EVENTS, CODE 15 REPORTS, AND/OR INTENSE ANALY SIS/RCAs COMPLETED, ETC.)

### Code 15 - Medication Overdose

79 y.o. patient with past medical history of malignant neoplasm of the tongue and seizures. Patient was completely bedbound and dependent on others for total care. Patient was noted to deteriorating and physician recommended hospice as he was rapidly declining and approaching death. The patient had been taking methadone 10mg every 8 hours prior to admission and there were orders to continue home medication. There was an error in preparing the medication resulting in 2 dose of methadone with a concentration of 100mg being administered to the patient inadvertently.

#### Code 15 - Wrong Site Thoracentesis

73 y/o patient admitted 8/3 for elective aortic valve replacement which she underwent on 8/4. On 8/8, pt was to undergo right-sided thoracentesis but it was noted after the procedure was completed that the left side was performed. Error was caught after the fact. Patient did require a thoracentesis on both sides but the consent was just for the right.