AMBULATORY RISK MANAGEMENT QUARTERLY REPORT QUARTER 3 CY23

Occurrence Category CY23 (BHP, BHPO, CDTC,BHW, BHC)	Q3	%
PATCARE	27	28%
SECURITY	20	21%
MEDICATION	19	20%
FALL	10	10%
SAFETY	8	8%
HIPAA/PHI	6	6%
LAB	4	4%
PPID	2	2.08%
Grand Total	96	100.00%

TOTAL OCCURRENCES CY23 Q3:

Number of reports decreased 5% when compared to previous quarter.
BHP reported 71% of all occurrences, BHCO 12%, BHPO 11%, BHCD 2% and Weston 3%.
An increase on medication variances was noted and pharmacy implemented an action plan in response.
Most occurrences involved patients (65%), employees accounted for 20%, others 15%.

PATIENT CARE CY23	Q3
TRANSFER TO HIGHER LEVEL OF CARE	8
AMA	4
BAKER ACT	3
DISRUPTIVE BEHAVIOR	3
PATIENT NONCOMPLIANCE	3
COMMUNICATION/HANDOFF	2
RAPID RESPONSE	2
DOCUMENTATION ISSUE	1
REFERRAL ISSUE	1
Total	27

PATIENT CARE:

BHP reported 22 of the 27 occurrences.
Appropriate steps followed for 3 Baker Act events.

SECURITY CY23	Q3
AGGRESSIVE BEHAVIOR	6
VEHICLE ACCIDENT	4
VERBAL ABUSE	3
SECURITY PRESENCE REQUESTED	3
TRESSPASS	2
PROPERTY DAMAGED/MISSING	2
Total	20

SECURITY:

Thirteen reports from BHP, 5 from BHCO and 2 BHPO.
Vehicle accidents reported to claims and insurance if involving BH vehicles. Car damage due to flood around ISC.
Police called for individual who walked into physician office building with a riffle and a bullet proof vest. BHIP CEO and CMO met with physician to reinforce expectations.
Individuals from "JTownPress" walked into 2 BHP locations filming and defending their rights to be at public spaces.

MEDICATION VARIANCES CY23	Q3
OTHER	5
WRONG FREQUENCY	3
WRONG DOSE	3
WRONG PATIENT	3
WRONG DRUG	3
PRESCRIBER ERROR	2
Total	19

MEDICATION VARIANCES:

Most events reported by BHP pharmacies. Six of the 19 occurrences did not take place at pharmacies.
Noted increased reporting during Q2 and Q3 (14,19) compared to Q1 (3).
Many failures related to the verification/data entry process. Action plan from pharmacy.
BHPO event involving wrong storage of Testosterone injections.

FALL CY23	Q3
FROM CHAIR	3
PATIENT STATES	3
FOUND ON FLOOR	2
TRIP	2
Total	10

FALL:

Reported by BHP, BHPO, BHCO and Weston.
Four employee falls, two visitors, two patients and one contractor. No injuries reported.
Facilities improved conditions of grassy parking lot across BHMC ED where

SAFETY CY23	Q3
SAFETY HAZARD	3
FALSE ALARM	2
CODE RED	1
ELECTRICAL HAZARD	1
GAS/VAPOR EXPOSURE	1
Total	8

SAFETY:

Occurrences from Corporate and BHP.
Diesel spill at ISC building due to generator pump valve malfunction.
Employees removed and clean up by contracted company. Facilities to obtain a second safety system for pressure relief valve and to connect system so on call gets notification of failures.
Code red occurred at ISC with employee's evacuation. False alarm per facilities and rescue.
Employee was shocked while using pin pad to enter peds at CEB. Facilities

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HIPAA/PHI CY23	Q3
PATIENT PRIVACY COMPLAINT	2
UNAUTHORIZED ACCESS	2
IDENTITY THEFT	1
IMPERMISSIBLE DISCLOSURE/PAPER	1
Total	6

HIPAA/PHI:

Reports from BHP, CDTC and BHPO.
Compliance further investigates HIPAA/PHI events and ensures employee corrective action process and retraining. No breaches identified and one pending.

LAB CY23	Q3
DELAYED RESULT	2
OTHER	1
MISLABELED SPECIMEN	1
Total	4

LAB:

All reported by BHP.
Prenatal labs stayed at Pompano after power outage during storm. Charge nurse did not activate chain of command. Labs went to Quest after hours, charts were reviewed and all tests completed.
Two tests not processed by Quest due to failure of their refrigerator. Redraws

PPID CY23	Q3
NO BAND	1
UNABLE TO ID	1
Total	2

PPID:

Wrong DOBs noted at BHP Pharmacy.
Re-education provided to PBO staff on how to document insurance issues without changing DOB at account level.
Front desk staff reinforced to obtain patient ID at registration to confirm full name, DOB and address.

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.)

Pharmacy Action Plan for Increased Medication Variances:
1. Human Error - Pharmacy personnel were provided coaching on
- the verification/data entry process and the importance of applying safe practices appropriately and consistently.
- the importance of using open-ended techniques in communications with patients to access their understanding proper patient identification process and procedure at the Point of Sale
2. Technology Error- Pharmacy System fixed the item selection safety feature which was incorrectly established
3. For Medication Variances that led to a patient ingesting the incorrect medication, frequency, dose and HIPPA breached led to either a Supervisory Note or Corrective Actions depending on whether the infraction was a first time or re-current by the same employee
4. Near Misses which were categorized by patients not ingesting the incorrect medication that was dispensed led to a verbal coaching with the employee(s)
5. All BHP Clinical Pharmacists completed HealthStream Module- Preventing and Reducing Medication Errors
6. Pharmacy Technicians involved in the incidents HealthStream Module- Preventing and Reducing Medication Errors
7. All Clinical Pharmacists completed this year a 2hr CE on Medication Error in order to renew our pharmacy license. This is through the Board of Pharmacy, which is a requirement every 2 years when renewing pharmacy licenses.

BHPO MA noticed that the vial of testosterone was gel-like as opposed to the usual fluid-like consistency.
Since beginning of 2023 when it was decided that the meds administered in the office were going to be provided by BH pharmacy instead of brought by the patients, all meds have been stored in the refrigerator.
Testosterone is provided by BHP pharmacy and is not transported refrigerated. All vials contain patient's name and are single use vials.
Office uses a log to document doses administered.
There were 3 patients that received bi-weekly doses of testosterone IM injections at Dr. S office. Records were reviewed.
BHPG has 3 other endocrinologists. According to nurse manager, Dr. B has testosterone stored at room temperature. Dr. P and Dr. B do not have patients on testosterone. Dr. M is at the same office as Dr. S but does not have patients on testosterone.
Only other medication that was stored in the refrigerator at Dr. S office is insulin which is appropriate.
Pharmacy reached out to the manufacturer and the guidance was to not use the medication if product has been stored contrary to their guidelines.
Testosterone should be stored at room temperature (20-25 Celsius) and protected from light.
All vials that were refrigerated were picked up on 7/20/23 from the office to be delivered to BPA.
Office supervisor sent prescription request to provider on 7/17/23 for vials replacement without billing insurances.
All 3 patients returned to see Dr. S between 8/8/23 and 8/10/23. The patients were informed that testosterone had been inappropriately started in the refrigerator. They reported no side effects of the testosterone injection as well as no changes in the efficacy of the medication. Notes entered in all 3 medical records.
Currier service was arranged to take vials to the pharmacy for proper disposal.
New prescriptions were requested so meds could be replaced appropriately. Insurance will not be billed again for these.

All ambulatory staff was alerted about how to proceed in case of a situation like the individuals recording at BHP sites.
Managers to disseminate information to staff.
- Inform the individuals that filming/recording is against Broward Health's policies.
- Refrain from interacting with the individuals.
- If there is security on site, call them.
- Remove patients and visitors from waiting areas as much as possible.
- Be extra careful with patient private information.
- Call the police.
- Inform risk management and complete a HAS Occurrence Report.

CDTC inquired about use of protective stabilization for dental care. According to nurse manager, current dentist has not used the papoose. She added it is sometimes used for blood draws due to special needs patients.
Article and a poster regarding nursing education on alternatives to its use for clinical care was shared with nurse manager and administration.
Papoose acts as restraints of patient's movements. Pharmacologic intervention and general anesthesia mentioned as safer, specially for dental care.
Recommendations to not use papoose at CDTC.