BHMC RISK MANAGEMENT QUARTERLY REPORT

Occurrence Category CY22 *(Patient Occurences Comparison Report)*	**Q3**	**%**
ADR	**1**	**0%**
DELAY	**24**	**2%**
FALL	**45**	**4%**
HIPAAPHI	**7**	**1%**
INFECTION	**6**	**0%**
LAB	**17**	**1%**
MEDICATION	**79**	**6%**
OBDELIVER	**106**	**9%**
PATCARE	**403**	**33%**
PATRIGHT	**1**	**0%**
PPID	**5**	**0%**
SAFETY	**15**	**1%**
SECURITY	**487**	**39%**
SKINWOUND	**9**	**1%**
SURGERY	**31**	**3%**
Grand Total	**1236**	**100%**

OCCURRENCE CATEGORY CY22:

Quarter 3 totaled 1236 occurrence variance reports as compared to Q2 which contained a total of 1156.

There were a total of 21reported near miss occurrences making up 1.7% of all occurrences.

Inpatient Falls by Category CY22 *(Comparison-binoculars- BHMC Inp Falls by Supcat -change date needed)*	**Q3**	**%**
Baby/Child Drop	**1**	**2.50%**
Child Fall during Play	**1**	**2.50%**
Eased to floor by employee	**1**	**2.50%**
Found on floor	**28**	**70.00%**
From Bed	**2**	**5.00%**
From Bedside Commode	**1**	**2.50%**
From Chair	**3**	**7.50%**
From Toilet	**1**	**2.50%**
Patient States	**2**	**5.00%**
Slip		**0.00%**
Trip		**0.00%**
While ambulating		**0.00%**
FALL Total	**40**	**100%**

INPATIENT FALLS BY CATEGORY CY22:

There were a total of 40 Inpatient Falls for Q3 Highest category for falls were Patients Found on Floor making up 70% of inpatient falls.

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

BHMC RISK MANAGEMENT QUARTERLY REPORT

OB DELIVERY CY22 *(Patient Occurences Comparison Report)*	Q3	%
Birth Trauma	1	0.94%
CPOE issue		0.00%
C-Section with no first assist	1	0.94%
Emergency C-Section > 30 min	2	1.89%
Fetal Distress		0.00%
Fetal/Maternal Demise	2	1.89%
Induction Bishop <6		0.00%
Infant d/c to wrong person		0.00%
Instrument Related Injury	1	0.94%
Maternal complications	2	1.89%
Maternal Tranfer To Higher Level Of Care	2	1.89%
Meconium Aspiration		0.00%
Meconiun staining		0.00%
Neonatal complications - Admit Mother/Baby		0.00%
Neonatal complications - Admit NICU	49	46.23%
Neonatal complications - Apgar <5 @5 min		0.00%
Neonatal complications - Impaired Skin Integrity	1	0.94%
Neonatal complications - IV Infiltrate	3	2.83%
OB Alert		0.00%
Other	23	21.70%
Postpartum Hemorrhage	5	4.72%
Return To Ldr (Labor Delivery Room)	1	0.94%
RN Atttended Delivery	7	6.60%
RN Unattended Delivery		0.00%
Shoulder Dystosia	4	3.77%
Sponge/Needle/Instrument Issues		0.00%
Sterile field contaminated		0.00%
Sugical Count	1	0.94%
Unplanned Procedure	1	0.94%
TOTAL	106	100%

OB DELIVERY CY22:

There were a total of 106 OB Delivery incidents for Q3

Highest category for incidents were related to Neonatal complications Admit to NICU which contributed to 46% of OB delivery related incidents.

HAPIs CY22 *(Report Listing by Category and look for TRUE HAPI's in SkinWound SkinBracq Pressure Injury - Acquired)*	Q3	%
Pressure Injury - Acquired	1	100%

HAPIS CY22:

There was 1 Hospital Acquired Injuries for Q3.
Occurred 7/12/22 CVICU Pt was on a Stryker Mattress and method has not been working. Pt has been admitted to hospital with now developed pressure ulcer.

BHMC RISK MANAGEMENT QUARTERLY REPORT

MEDICATION VARIANCES *(Patient Occurences Comparison Report))*	Q3	%
Contraindication		0.00%
Control Drug Charting		0.00%
Control Drug Discrepancy Investigation		0.00%
Delayed Dose	23	29.11%
eMar - Transcription/Procedure	2	2.53%
Expired Medication	1	1.27%
Extra Dose	3	3.80%
Improper Monitoring	5	6.33%
Labeling Error	1	1.27%
Missing/Lost Medication	1	1.27%
Omitted Dose	10	12.66%
Other	4	5.06%
Prescriber Error	2	2.53%
Pyxis Count Discrepancy		0.00%
Pyxis Miss Fill	1	1.27%
Reconciliation		0.00%
Scan Failed	3	3.80%
Self-Medicating	2	2.53%
Unordered Drug		0.00%
Unsecured Medication	1	1.27%
Wrong Concentration	4	5.06%
Wrong Dosage Form	4	5.06%
Wrong Dose	7	8.86%
Wrong Drug or IV Fluid	1	1.27%
Wrong Frequency or Rate	1	1.27%
Wrong Patient		0.00%
Wrong Route	1	1.27%
Wrong Time	2	2.53%
MEDICATION Total	79	100%

MEDICATION VARIANCES CY22:

There was a total of 79 medication variances for Q3.

Highest med varicance category was due to Delayed Dose,which contributed to 29% of total medication 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 *(Patient Occurences Comparison Report)*	Q3	%
Dermatological	1	50.00%
Miscellaneous	1	50.00%
ADR Total	2	100%

ADR CY22:

Total of 2 ADR in Q3 2022.

BHMC RISK MANAGEMENT QUARTERLY REPORT

SURGERY RELATED ISSUES CY22 *(Patient Occurences Comparison Report)*	Q3	%
Anesthesia Complication	1	3.23%
Consent Issues	3	9.68%
CPOE issue		0.00%
Extubation/Intubation		0.00%
Incorrect information on patient's chart		0.00%
Positioning Issues	1	3.23%
Puncture or Laceration	1	3.23%
Retained Foreign Body		0.00%
Sponge/Needle/Instrument Issues	3	9.68%
Sterile field contaminated	4	12.90%
Surgery Delay		0.00%
Surgery/Procedure Cancelled	2	6.45%
Surgical Complication	5	16.13%
Surgical Count	9	29.03%
Surgical site marked incorrectly		0.00%
Tooth Damaged/Dislodged		0.00%
Unplanned Return to OR	1	3.23%
Unplanned Surgery	1	3.23%
Wrong Patient		0.00%
Wrong Procedure		0.00%
Wrong Site		0.00%
SURGERY TOTAL	31	100%

SURGERY RELATED ISSUES CY22:

There was a total of 31 surgery related issues for Q3.

Highest category for incidents were related to Surgical Count which contributed to 29% of surgical related incidents.

SECURITY CY22 *(Patient Occurences Comparison Report)*	Q3	%
Abduction		0.00%
Access control		0.00%
Active Shooter		0.00%
Aggressive behavior	25	5.13%
Armed Intruder	1	0.21%
Arrest	1	0.21%
Assault/Battery	14	2.87%
Break-in	1	0.21%
Code Assist		0.00%
Code Black		0.00%
Code Elopement	7	1.44%
Code Green		0.00%
Code Stork		0.00%
Code Strong		0.00%
Contraband	18	3.70%
Criminal Event		0.00%
Elopement -Involuntary admit (BA, patient's under police custody, vulnerable adults etc.)	1	0.21%
Elopement -Voluntary admit (persons admitted on their own accord/will; non-vulnerable individuals)	4	0.82%
Property Damaged/Missing	25	5.13%
Rapid Response Team - Visitor		0.00%
Security Assistance *new August 2022	50	10.27%
Security Presence Requested	332	68.17%
Security Transport	3	0.62%
Smoking Issues	1	0.21%
Threat of violence	2	0.41%
Trespass		0.00%
Vehicle Accident	1	0.21%
Verbal Abuse	1	0.21%
SECURITY TOTAL	487	100%

SECURITY CY22:

There was a total of 487 security incidents for Q3.

Highest incidents reported were related to Security Presence Requested which was 68% of total security related incidents.

BHMC RISK MANAGEMENT QUARTERLY REPORT

SAFETY CY22	Q	%
Biohazard Exposure		0.00%
Code Red		0.00%
Code Spill - Chemical		0.00%
Code Spill - Chemo		0.00%
Electrical Hazard		0.00%
Elevator entrapment		0.00%
False Alarm		0.00%
Fire/Smoke/Drill		0.00%
Gas/Vapor Exposure		0.00%
Safety Hazard	15	100%
Sharps Exposure		0.00%
SAFETY Total	15	100%

SAFETY CY22:

There was a total of 15 Safety incidents for Q3.

Highest incidents reported were related to Safety Hazard which was 100% of total safety 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.)

No Reportable Adverse Events to the State

RCA's/IA's:

NICU D10 Incident: This case involved twins, who were born at 25 weeks via C-section at Broward Health Coral Springs. Because of the extreme prematurity of the children, they were transferred to BHMC to the NICU. In the early part of their admission, the children had umbilical lines. A standard practice is to infuse in the umbilical lines normal saline at a KVO rate. This was done. It is also not abnormal for extremely premature to have elevated blood glucose levels and to require treatment with insulin drips. That was occurring with these children. This did not seem out of the ordinary, except that the patients' blood sugar in this case kept going up and was not responding to the insulin. The KVO fluid was taken down and brought to the pharmacy, who confirmed that there was dextrose in the fluid. This was discontinued and the patients' blood sugars quickly returned to normal. It was discovered that the KVO fluid was actual a Dextrose solution causing the elevated blood sugars.
Actions: Since the event and going forward, in the compounding hood, the technician will only have two active jobs going to reduce distraction

The pharmacist double check of the compounding jobs, which before had just been a visual confirmation, is now recorded on a log with the medications, lot #'s and manufacturers. The log is signed off by the pharmacist to confirm the work

ER Blue Door Failure and Elopement: An ER psychiatric patient was able to elope by pushing through the door, that is supposed to be secured and locked. He was able to make it outside the facility and down the street. The patient was recovered unharmed.
Actions: Door access to those doors will be limited to Security, Facilities, and the ER manager.

All security offices will carry radios (lack of a radio prevented communication of the patient's location during the pursuit

Maintenance check of doors

Establishing a task force to continue to work on the clinical issues of the case, to include medication of the psychiatric patients, CPI training, whistles for the ED staff

4NT Stabbing Incident: A family dispute involving visitors of a dying woman, resulted in a physical altercation that ended up in the nurses station, with one family grabbing a nurse to use as a shield to prevent the other family member from stabbing him. The nurse escaped, the one family member stabbed the other, and ran away. The man who was stabbed was taken to the OR as a trauma patient.
Actions: Surveillance cameraas installed, and panic buttons with direct links to security installed on the phones.

Staff participated in supplementing FLPD's report to include details of the using the nurse as a shield, as well