# RISK MANAGEMENT QUARTERLY REPORT QUARTER 2

| Occurrence Category CY21 | Q2 | % |
|---|---|---|
| DELAY | 30 | 2.39% |
| FALL | 79 | 6.29% |
| HIPAAPHI | 7 | 0.56% |
| INFECTION | 3 | 0.24% |
| LAB | 31 | 2.47% |
| MEDICATION | 89 | 7.09% |
| OBDELIVER | 79 | 6.29% |
| PATCARE | 429 | 34.16% |
| PATRIGHT | 1 | 0.08% |
| PPID | 3 | 0.24% |
| SAFETY | 26 | 2.07% |
| SECURITY | 435 | 34.63% |
| SKINWOUND | 7 | 0.56% |
| SURGERY | 37 | 2.95% |
| Grand Total | 1256 | 100.00% |

**OCCURRENCE CATEGORY CY21:**

During the 2nd Quarter CY 2021 there were a total of 1256 occurrence variance reports compared to 1269 during the 1st Quarter CY 2021 reflecting a 1.02% increase in reporting. There were a total of 51 reported near miss occurrences making up 4.06% of all occurrences.

| Inpatient Falls by Category CY21 | Q2 |
|---|---|
| Eased to floor by employee | 1 |
| Found on floor | 32 |
| From Bed | 8 |
| From Bedside Commode | 3 |
| From chair | 2 |
| From Toilet | 1 |
| Patient States | 5 |
| Slip | 1 |
| Visitor Fall While Ambulating | 1 |
| While ambulating | 8 |
| Total Inpatient Falls | 62 |

**INPATIENT FALLS BY CATEGORY CY21:**

There were 62 falls reported during the 2nd Quarter of 2021, a 8.82% decrease from Q1 CY21 . The incidents occurred on the following departments: 3NT (9), 4NWW (1), 4SWW (15), 4Atrium (13), 5NT (4), 5ST (3), 5Atrium (6), 6NT (1), 6ST (5), Peds Hem/Once (1), CCU (1), CVICU (1), PICU (1), and RCU (1).

There was 9 falls with injuries reported during the 2nd Quarter CY21 – (1) fall with fracture, (5) fall with abrasion; (1) fall with laceration; (2) falls with skin tears.

| OB DELIVERY CY21 | Q2 |
|---|---|
| C-Section with no first assist | 1 |
| Fetal Distress | 1 |
| Instrument Related Injury | 1 |
| Maternal complications | 3 |
| Maternal Transfer To Higher Level Of Care | 2 |
| Neonatal complications - Admit NICU | 43 |
| Neonatal complications - Apgar <5 @5 min | 2 |
| Neonatal complications - Impaired Skin Integrity | 2 |
| Neonatal complications - IV Infiltrate | 1 |
| OB Alert | 1 |
| Other | 4 |
| Postpartum Hemorrhage | 5 |
| RN Attended Delivery | 3 |
| Shoulder Dystocia | 7 |
| Unplanned Procedure | 3 |
| OBDELIVER Total | 79 |

**OB DELIVERY CY21:**

All NICU admissions were unrelated to an adverse event but due to the infants' condition and MD requesting infants' to be transferred to NICU for closer observations.

All shoulder dystocia and postpartum hemorrhage cases are sent to Quality for further review.

No trends identified.

| HAPIs CY21 | Q2 |
|---|---|
| Pressure Injury - Acquired | 1 |

**HAPIs CY21:**

Patient developed an Unstageable HAPI.

45-year-old male admitted 4/11/2021 s/p witnessed V-fib cardiac arrest. 30-35 minutes of CPR/ACLS until ROSC. Patient underwent hypothermia protocol.
Wound care consulted on 4/22 for moisture/friction partial thickness at natal cleft. Discoloration also seen on right lateral heel. Venelex recommended.

Wound care team attempted to assess patient multiple times however, patient was too unstable to be turned. Wound care continued to follow patient throughout their hospital course.

Opportunity identified with RN not to use fitted sheets on low air loss beds.

| MEDICATION VARIANCES CY21 | Q2 |
|---|---|
| Contraindication | 5 |
| Control Drug Discrepancy Investigation | 1 |
| Control Drug Discrepancy-count | 1 |
| Control Drug Diversion/Suspicion | 3 |
| Delayed dose | 5 |
| Extra Dose | 6 |
| Improper Monitoring | 5 |
| Labeling Error | 1 |
| Missing/Lost Medication | 1 |
| Omitted dose | 10 |
| Other | 9 |
| Prescriber Error | 5 |
| Pyxis Miss Fill | 3 |
| Reconciliation | 1 |
| Scan Failed | 2 |
| Unordered Drug | 2 |
| Unsecured Medication | 1 |
| Wrong Concentration | 3 |
| Wrong dosage form | 4 |
| Wrong dose | 9 |
| Wrong Drug or IV Fluid | 4 |
| Wrong frequency or rate | 3 |
| Wrong patient | 3 |
| Wrong route | 2 |
| MEDICATION Total | 89 |

**MEDICATION VARIANCES CY21:**

50.8% increase in medication variances from 59 Q1 CY21 to 89 Q2 CY21 of which 34 were near misses. No Adverse Outcomes. 77 occurrences were on the Adult units and 12 on the Women and Children's units.

All discrepancy investigation were reviewed, it was determinized that they were not purposeful diversions. All employee involved will have increased monitor to verify that no further diversion occurs.

| ADR CY21 | Q2 |
|---|---|

**ADR CY21:**
None reported

| SURGERY RELATED ISSUES CY21 | Q2 |
|---|---|
| Anesthesia Complication | 1 |
| Consent Issues | 1 |
| Extubation/Intubation | 1 |
| Positioning Issues | 2 |
| Puncture or Laceration | 1 |
| Sponge/Needle/Instrument Issues | 2 |
| Sterile field contaminated | 5 |
| Surgical Count | 12 |
| Surgery Delay | 2 |
| Surgery/Procedure Cancelled | 2 |
| Surgical Complication | 4 |
| Tooth Damaged/Dislodged | 1 |
| Unplanned Return to OR | 2 |
| Unplanned Surgery | 1 |
| SURGERY Total | 37 |

**SURGERY RELATED ISSUES CY21:**

All surgical count related issues came back with negative x-ray results.

There was an incident in CPD where the sterilization process was not followed. Error was caught prior to reaching any patients and all unsterile trays were identified and removed. No further incidents reported since.

| SECURITY CY21 | Q2 |
|---|---|
| Access control | 2 |
| Aggressive behavior | 17 |
| Assault/Battery | 33 |
| Break-in | 1 |
| Code Assist | 106 |
| Code Black | 2 |
| Code Elopement | 8 |
| Code Stork | 1 |
| Code Strong | 2 |
| Contraband | 12 |
| Elopement -Voluntary admit (persons admitted on their own accord/will; non-vulnerable individuals) | 8 |
| Property Damaged/Missing | 17 |
| Security Presence Requested | 219 |
| Threat of violence | 4 |
| Vehicle Accident | 2 |
| Verbal Abuse | 1 |
| SECURITY Total | 435 |

**SECURITY CY21:**

6.45% decrease in security reporting from 465– Q1 CY21 to 435– Q2 CY21. 45.29% of all security incidents are related to our Behavioral Health Population.

IST team continues to follow up with staff who have been injured by patients.

Code Stork was called on a patient who was discharged however not ready to leave the unit. Patient was found and brought back. More information provided below.

## RISK MANAGEMENT QUARTERLY REPORT QUARTER 2

| SAFETY CY21 | Q2 |
|---|---|
| Biohazard Exposure | 2 |
| Code Red | 5 |
| Electrical Hazard | 1 |
| Safety Hazard | 13 |
| Sharps Exposure | 5 |
| SAFETY Total | 26 |

**SAFETY CY21:**

27.77% decrease in Safety reporting from 36– Q1 CY21 to 26– Q2 CY21.

**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 Stork:**
Mom and Baby were discharged from the unit on 6/9/21 at 1145hrs. The mother was initially waiting for her husband to come. Around 1630 when asked by staff, she reported she was waiting for a girlfriend to pick her up with the car seat that had been ordered from Walmart. Mom was told at this time to call when she was ready to go so the security tag system could be cut off. Mom never called to say she was ready to go after the arrival of her friend. Just past 1700, after the arrival of her girlfriend with the car seat, the friend, the mom, the baby, and a toddler all walked off the unit. They were buzzed out of the door and proceeded to leave the hospital. The HUGS tag system went off first with a Tag Exit alarm, followed by a Tag Supervision alarm which negated the Tag Exit alarm. Staff knowing that the mom was pending discharge ran to check on her an realized she was gone. A Code Stork was called and staff left the unit to look for her. She was found just outside the lobby waiting for her ride on one of the benches. She was brought back to the unit for the removal of the security tag, and the operators were called to cancel the Code Stork.

**FMS:**
The patient is a 48 Years old M, who was intubated in the CCU with complications related to potential alcohol withdrawal and cardiomyopathy. In addition, he was treated with lactulose enemas given his elevated ammonia related to shock liver after his recent cardiac arrest. Over the last 24 hours, he was noted to have increased abdominal distention, culminated the morning of 4/11 by extreme abdominal tightness, and associated increasing ventilatory peak pressures as well as acute oliguria to eventual anuria. Given the very real concern for abdominal compartment syndrome, Surgery was consulted to evaluate the patient. The recent KUB was reviewed, which appeared to have an extremely dilated colon. Given this distention, the first immediate therapeutic action by the surgeon was to attempt decompression with a rectal tube.

A 30 French Foley was obtained, with plans to insert as far as possible to alleviate some of intra-abdominal pressure. The patient had a fecal management system inserted, which was held in place by the balloon at the end of it. These balloons typically carry no more than 45 cc of fluid, so the surgeon began to aspirate the fluid with a 10 cc syringe, to be able to remove the tube. He removed 30 cc of fluid, which was noted to be slightly yellow in color, but found the tube to still be very fixed in its position. The surgeon aspirated 10 more cc, and then 10 more cc's. He did this until removing approximately 130-150cc of fluid. At this point, lose fecalized fluid began to drain out the rectum and into the tube as well as from around the tube as well as some gas. He switched to a 50 cc syringe, and aspirated 3 more full syringes of fluid, all with the light pale yellow color. As this was done, there was a massive exodus of fluid and gas from the rectum, and the abdomen began to feel markedly softer. In addition, ventilatory peak pressures decreased remarkably, and even the blood pressure demonstrated a moderate increase.

Ultimately, the patient continued on his complicated course post cardiac arrest, needing pressors and other interventions until he cardiac arrested again and ultimately died.