RISK MANAGEMENT QUARTERLY REPORT QUARTER 2

Occurrence Category CY21	Q2
ADR	8
DELAY	31
FALL	62
HIPAAPHI	5
INFECTION	7
LAB	6
MEDICATION	50
PATCARE	265
PPID	0
SAFETY	13
SECURITY	315
SKINWOUND	44
SURGERY	16
Total	822

OCCURRENCE CATEGORY CY21:
Decrease in occurence variance reports from 859 in Q1 to 852 in Q2, reflecting a 0.8% decrease. The Patient Care occurences increased from 245 to 265 reports and Medication Variances decreased from 54 in Q1 to 50 in Q2. No other trends noted. The overall Near Miss Occurrences during the 2nd Quarter CY 21 were 13, or 1.6% of overall occurrences. The goal continues to be increased reporting to discern trends in order to implement risk reduction measures.

Inpatient Falls by Category CY21	Q2
FALL EASED TO FLOOR BY EMPLOYEE	9
FOUND ON FLOOR	22
FALL FROM BED	4
FALL FROM EQUIPMENT	1
FALL FROM TOILET	1
FALL PATIENT STATES	1
FALL WHILE AMBULATING	1
SLIP	3
Grand Total	41

INPATIENT FALLS BY CATEGORY CY21:
Increase in falls from 34 to 41 in Q2, reflecting a 21% increase. Increase in eased to floor by employee from 4 to 9. No injuries from any of the falls. All patient falls are discussed daily during the morning huddle and a fall intense analysis is completed for each.

HAPIs CY21	Q2
Stage 2	1
DTI	1
Total	2

HAPIS CY21: 2 HAPIs in Q2 compared to 3 HAPIs in Q1. No trends. NM performs intense analysis per HAPI. No HACs reported for Q2. Rate of 0.10 with target of 0.36.

MEDICATION VARIANCES CY21	Q2
Contraindication	2
Control Drug Charting	1
Delayed dose	9
Expired Medication	1
Extra Dose	7
Improper Monitoring	4
Missing/Lost Medication	1
Omitted dose	2
Other	4
Prescriber Error	3
Pyxis Miss Fill	2
Reconciliation	2
Self Medicating	1
Wrong Dosage Form	1
Wrong Dose	1
Wrong Drug or IV Fluid	3
Wrong Frequency or Rate	2
Wrong Patient	4
Total	50

MEDICATION VARIANCES CY21: Rate of 0.01%. Decrease in medication variances by 7%, from 54 to 50. Risk, nursing, and administration collaborate monthly to discuss medication variances, trends, and lessons learned from medication variances. Lessons learned are based on trends or high-risk/frequesncy items that can be avoided. They are then distributed to staff by various methods such as created into videos produced and starred in by phamacy staff, emailed to all BHN in CEO newsletter, or played on the tv outside of main hospital elevators. Lessons learned discussed in Risk Management section at the bottom of this report. Lessons learned and opportunities are also reviewed in Patient Care Key Group by pharmacy manager. No adverse outcomes. Goal continues to be increased reporting.

ADR CY21	Q2
Allergy	4
Hematological/Blood Disorder	2
Miscellaneous	2
Total	8

ADR CY21: 8 ADR in each Q1 and Q2. No adverse outcomes.

SURGERY RELATED ISSUES CY21	Q2
Extubation/Intubation	2
Surgery Delay	2
Surgery/Procedure Cancelled	5
Surgical Complication	1

SURGERY RELATED ISSUES CY21: 13 Surgical-related issues in Q1 compared with 16 in Q2, a 23% increase. Cancelled surgeries increased from 2 to 5 in Q2. Surgical complications and surgery delays remained the same at 1 and 2,

Tooth Damage/Dislodged	2
Unplanned Return to OR	4
Total	16

respectively. Surgical complication included event in which GI physician was inserting PEG tube at bedside in ICU and during insertion, plastic cannula got lost in anterior abdominal wall vs peritoneum. MD decided not to pursue further and called surgeon. Event disclosed to wife who then completed informed consent for procedure to remove cannula. Patient brought to OR so proedure could be completed in controlled environment as GI doctor believed this would be in the nest interest of the patient. Cannula successfully removed from patient. Unplanned return to OR increased from 1 to 4, all of which sent to quality for further review.

SECURITY CY21	Q2
Aggressive behavior	10
Assault/Battery	7
Break-In	1
Code Assist	126
Code Black	1
Code Elopement	17
Contraband	44
Elopement- Voluntary Admit	4
Property Damaged/Missing	23
Security Presence Requested	76
Security Transport	2
Threat of violence	1
Vehicle Accident	3
Total	315

SECURITY CY21: Decrease in security occurrences from 337 in Q1 to 315 in Q2, reflecting a 7% decrease. Code Assists decreased from 175 in Q1 to 126 in Q2, reflecting a 28% decrease. Security Presence Requested decreased from 87 to 76. Assault/battery increased from 4 to 7. Out of the 23 missing/damaged property, only one item was missing and substantiated.

SAFETY CY21	Q2
Biohazard Exposure	1
Code Red	5
False Alarm	1
Safety Hazard	6
Total	13

SAFETY CY21: Decrease in safety occurrences from 22 Q1 to 13 in Q2 which indicates a 41% decrease.Decrease sharps exposures and false alarms from 7 and 4, respectively, in Q1 to 0 in Q2. Four false alarm reports in Q1 (none in Q4) and safety hazard/sharps exposure remained consistent with 6 each in Q4 compared with 7 each in Q1. Sharps explosures were discussed in previous quarter process improvement which detailed risk reduction measures of education to staff on replacement syringes and safe injection practices.

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 Code 15 Reports.**

❖ **FMEA**

Education dispersed to selected staff in the form of a healthstream presentation with related quiz to reinforce content.

❖ **Medication Variance Lessons Learned:**

- Review MAR for prior administration times to ensure doses are not given too close together.
- Read and evaluate alerts/warnings when entering medications. Don't fall victim to alert fatigue.
- Remind nurses to look back and do a quality chart review.
- Question all duplicate orders.
- During Medication Reconciliation be aware of look alike sound alike medications and use external Rx history to verify.
- Patient Own Meds: Send home with patient if possible, if not, bag and send to pharmacy for storage. If order for patient to take while hospitalized, get physician order, send to pharmacy to identify and re-label.

❖ **Action Plans:**

- **Calling for assistance in the cardiac cath lab**
  - **<u>Opportunities:</u>** Consider adding sequence of physicians to call for response to Code Blues and make operators aware; establish a Cath lab intubation call sequence in a non-anesthesia case
  - **<u>Actions:</u>** Modify Code Blue policy to add sequence of physician calls for in-house codes outside of ED and OR; Educate telephone operators on call procedures; Reinforce intubation call sequence for cath lab cases

- **Anesthesia participation in urologic surgical case**
  - **<u>Opportunities:</u>** Multiple cases booked for a Sunday with limited surgical staff; Confusion regarding trauma team standards; Limited staff to take OR cases on weekends
  - **<u>Actions:</u>** Create policy/protocol for booking surgical cases on weekends and send to surgeons; Create list of cases that are elective, urgent, and emergent for weekends and then send to surgeons; Reinforce trauma requirements and trauma teams with surgical staff; Reinforce escalation of issues; Review trauma team standards/ weekend scheduling at OR Committee meeting; Hire extra OR team members for weekend surgeries