BHMC RISK MANAGEMENT QUARTERLY REPORT QUARTER 4 CY23

Occurrence Category CY23 *(Patient Occurrences Comparison Report from OVR Stats page)*	Q4	%
ADR	2	0%
DELAY	50	4%
FALL	85	6%
HIPAAPHI	7	1%
INFECTION	2	0%
LAB	31	2%
MEDICATION	104	8%
OBDELIVER	61	4%
PATCARE	457	33%
PATRIGHT	3	0%
PPID	4	0%
SAFETY	33	2%
SECURITY	358	26%
SKINWOUND	129	9%
SURGERY	50	4%
Grand Total	1376	100%

OCCURRENCE CATEGORY CY23:

During CY23 Q4 there were a total of 1376 patient occurrences as compared to Q3 which totaled 1545 patient occurrences reflecting an 11% decrease in overall occurrences from Q3 to Q4. There were a total of 46 reported near miss occurrences making up 3.3% of all occurrences.

Inpatient Falls by Category CY23 *(Comparison-binoculars- BHMC Inp Falls by Subcat -change date needed)*	Q4
Child Developmental	
Child fall during play	
Eased to floor by employee	3
Eased to floor by non employee	1
Found on floor	34
From Bed	8
From Bedside Commode	1
From Chair	
From Equipment, i.e. stretcher, table, etc.	1
From Toilet	6
Patient States	5
Slip	3
Visitor States	
While ambulating	4
Inpatient Fall Total	66

INPATIENT FALLS BY CATEGORY Q4 CY23:

There were a total of 66 Inpatient Falls for Q4 a 78% increase from Q3 (37) .

There was 14 (21%) falls with injuries reported during Q4:
(3) Abrasion
(1) Bruise/Contusion/Crushing
(2) Laceration
(3) Hematoma
(1) Pain
(2) Skin Tear
(1) Sutures/Staples/Steristrips
(1) Tear
Falls are discussed and reviewed for lessons and opportunities at

OB DELIVERY CY23 *(Patient Occurrences Comparison Report from OVR Stats page)*	Q4
Birth Trauma	-
CPOE issue	-
C-Section with no first assist	-
Emergency C-Section > 30 min	1
Fetal Distress	-
Fetal/Maternal Demise	1
Induction Bishop <6	-
Infant d/c to wrong person	-
Instrument Related Injury	-
Maternal complications	5
Maternal Transfer To Higher Level Of Care	3
Meconium Aspiration	-
Meconium staining	-
Neonatal complications - Admit Mother/Baby	-
Neonatal complications - Admit NICU	19
Neonatal complications - Apgar <5 @5 min	1
Neonatal complications - Impaired Skin Integrity	-
Neonatal complications - IV Infiltrate	-
OB Alert	-
Other	3
Postpartum Hemorrhage	20
Return To Ldr (Labor Delivery Room)	-
RN Attended Delivery	-
RN Unattended Delivery	5
Shoulder Dystocia	1
Sponge/Needle/Instrument Issues	-
Sterile field contaminated	-
Surgical Count	-
Unplanned Procedure	2
OB Delivery Total	61

OB DELIVERY Q4 CY23:

There were a total of 61 OB Delivery incidents for Q4 with a decrease of 40% from Q3 (102) .

None of thr NICU admission were related to an adverse event.
All PPH were sent to Quality for review.

HAPIs CY23 *Browse - Binoculars - BHMC HAPIs and HAPI Comp Rpt by Inj Type for injury type breakdown*	Q4
Pressure Injury - Acquired	20

Injury Type	4th Quarter
Decubitus - Stage I	
Decubitus - Stage II	2
Decubitus - Stage III	2
Decubitus - Stage IV	
Deep Tissue Injury	12
Unknown	
Unstageable Ulcers	4
Grand Total	20

HAPIS Q4 CY23:

There were 20 Hospital Acquired Injuries for Q4.
6 out of the 20 were reportable.

MEDICATION VARIANCES (Patient Occurrences Comparison Report on OVR Stats page)	Q4
Contraindication	6
Control Drug Discrepancy Investigation	-
Control Drug Charting	2
Control Drug Discrepancy-count	-
Control Drug Diversion/Suspicion	-
CPOE issue	1
Delayed dose	8
eMAR - Transcription/Procedure	1
Expired Medication	4
Extra Dose	6
Hoarding Medications For Later Use	-
Illegible Order	-
Improper Monitoring	7
Labeling Error	4
Missing/Lost Medication	2
Omitted dose	4
Other	14
Prescriber Error	3
Pyxis Count Discrepancy	-
Pyxis False Stockout	-
Pyxis Miss Fill	-
Reconciliation	1
Return Bin Process Error	1
Scan Failed	-
Self-Medicating	-
Unordered Drug	2
Unsecured Medication	3
Wrong Concentration	1
Wrong dosage form	5
Wrong dose	9
Wrong Drug or IV Fluid	13
Wrong frequency or rate	2
Wrong patient	1
Wrong Route	4
Wrong time	-
Med Variance Total	104

MEDICATION VARIANCES Q4 CY23:

There was a total of 104 medication variances for Q4 with a decrease of 10.34% from Q3 (116) .

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)*	Q4
Cardiopulmonary	2
ADR Total	2

ADR Q4 CY23:

SURGERY RELATED ISSUES CY23 *(Patient Occurrences Comparison Report from OVR Stats page)*	Q4
Anesthesia Complication	-
Consent Issues	17
CPOE issue	-
Surgery Delay	2
Extubation/Intubation	-
Puncture or Laceration	1
Retained Foreign Body	-
Surgery/Procedure Cancelled	1
Surgical Complication	3
Sponge/Needle/Instrument Issues	5
Sterile field contaminated	5
Surgical Count	10
Incorrect information on patient's chart	-
Positioning Issues	-
Surgical site marked incorrectly	1
Tooth Damaged/Dislodged	1
Unplanned Surgery	2
Unplanned Return to OR	2
Wrong Patient	-
Wrong Procedure	-
Wrong Site	-
Surgery TOTAL	50

SURGERY RELATED ISSUES Q4 CY23:

There was a total of 50 surgery related issues for Q4 with a 29% decrease from Q3(70) .

SECURITY CY23 *(Patient Occurrences Comparison Report from OVR Stats page)*	Q4
Abduction	-
Access control	-
Aggressive behavior	23
Armed Intruder	-
Arrest	-
Assault/Battery	16
Break-in	-
Code Black	-
Code Elopement	6
Code Pink	-
Code Strong	-
Contraband	9
Criminal Event	-
Elopement -Involuntary admit	1
Elopement -Voluntary admit	3
Property Damaged/Missing	16
Rapid Response Team - Visitor	1
Security Assistance *new August 2022	105
Security Presence Requested	132
Security Transport	-
Smoking Issues	1
Threat of violence	6
Trespass	2
Vehicle Accident	4
Verbal Abuse	33
Security Total	358

SECURITY Q4 CY23:

There was a total of 358 security incidents for Q4 with a 13 % decrease in security occurrences from Q3 (412) .

112 (31%) of security incidents were related to BH and Psych ED patients.

SAFETY CY23 *(Patient Occurrences Comparison Report from OVR Stats page)*	Q4
Biohazard Exposure	-
Code Red	10
Code Spill - Chemical	-
Code Spill - Chemo	-
Electrical Hazard	-
Elevator entrapment	-
False Alarm	-
Fire/Smoke/Drill	-
Gas/Vapor Exposure	-
Safety Hazard	14
Sharps Exposure	9
Safety - Other (no category)	-
Safety Total	33

SAFETY Q4 CY23:

There was a total of 33 Safety incidents for Q4 with a 37 % decrease in safety occurrences from Q3 (52) .

Highest category for incidents were related to Safety Hazard.

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.)

IA:
75 y/o M presented as transfer from BHN with difficulty breathing. CTA from BHN at 19:54 revealed large bilat PE with evidence of R heart strain; spiculated nodule RUL; few small patchy areas of interstitial infiltrates bilat.
On 10/21/23 patient was attempting to get out of bed and became aggressive with sitter who was trying to get the patient back to his bed. Patient attempted to push the sitter and lost his balance resulting in hem falling on the floor and hitting his head. The patient was noted to be on Eliquis at the time of the fall. MD was notified and CT of the brain was ordered. The first CT was negative for any injuries. The next day the patient was noted to be lethargic and a repeat CT was done that demonstrated a subdural bleed. Patient was transferred to ICU for closer monitoring.
IA:
40 y/o M presented with bilateral lower extremity swelling, testicular swelling, and abdominal swelling x3-4 weeks. PMH ETOH abuse, Hep C. Patient stated to ED MD that he drinks daily, and last drink was this morning. Hep C reactive on ED labs.
During the patient's admission the patient fell a few hours after his endoscopy procedure. A CT of the brain showed the patient had a small subdural hematoma. Neurosurgery was consulted and the patient did not require surgical intervention required. The patient was admitted to the ICU for closer monitoring. CT remained stable and discharged to hospice due to end stage renal and liver disease. During the meeting the RN caring for the patient stated that she educated him that his legs were weak and that if he needed any assistance that he should call her. She assisted the patient with the urinal to pee prior to leaving the room. The patient was noted to have anti-skid socks on. The fall occurred 10 minutes after the nurse had left the room. When asked why he was getting out of bed the patient stated he had to pee despite RN assisting patient 10 minutes prior. After the fall it was noted that the bed had malfunctioned, and the bed was removed from service.
IA:
83-year-old female with medical history of advanced Alzheimer's disease and dementia who presented to the ER via EMS after she was found at home unresponsive to verbal stimuli and somnolent. Urine tox screen positive for benzodiazepine. ICU was consulted for altered mental status. Daughter stated around 7:00 p.m. this afternoon 11/14/23 she found her mother sitting on a couch unresponsive and not following command. She subsequently called the EMS and patient was transported to the ER.
At around 1230, thud sound was heard from the room by the RN. PCA on shift this evening happened to be in the nutrition room at the time of the fall. RN saw head injury/hematoma on patient's head. RN VG contacted Dr O. Neuro consult done. Orders to give Levonox and wait for Dr K to see pt in morning were told to RN. No new orders for neuro checks were given. Dr R was consulted. Dr C stated if a fall has a bleed the intensivist is contacted and intensivist then reaches out to trauma.
Pt became worse overnight and was transferred to ICU.