BHMC RISK MANAGEMENT QUARTERLY REPORT

(HAS Comparison - binoculars - BHMC PCKG Near Miss)

Occurrence Category CY24 (OVR Stats Page and Patient Occurrences)	Q3
ADR	2
DELAY	29
FALL	60
HIPAAPHI	9
INFECTION	4
LAB	30
MEDICATION	71
OBDELIVER	92
PATCARE	329
PATRIGHT	1
PPID	4
SAFETY	23
SECURITY	237
SKINWOUND	118
SURGERY	71
Grand Total	1080

OCCURRENCE CATEGORY CY24:

CY24 Q3 had a total of 1080 patient occurrences as compared to Q2 which totaled 1189 patient occurrences reflecting a 9.16% decrease in overall occurrences from Q2 to Q3.

There were a total of 25 reported near miss occurrences making up 2.31% of all occurrences.

Inpatient Falls by Category CY24 *(Comparison-binoculars- BHMC Inp Falls by Subcat - change date needed)	Q3
Baby/Child Drop	1
Child Developmental	1
Child fall during play	-
Eased to floor by employee	3
Eased to floor by non employee	2
Found on floor	18
From Bed	11
From Bedside Commode	1
From Chair	-
From Equipment, i.e stretcher, table, etc.	-
From Toilet	-
Patient States	2
Slip	-
Visitor States	-
While ambulating	3
Inpatient Fall Total	42

INPATIENT FALLS BY CATEGORY Q3 CY24:

There were a total of 42 Inpatient Falls for Q3

There was 7 falls with injuries reported

Breakdown is as follows:
Abrasion: 1
Brain Bleed : 1
Skin Tear: 1
Laceration : 3
Hematoma: 1

Falls committee met in September and we will be reviewing all falls. Discussion was help related to possible initiative and creating a Falls Class for employees to attend.

OB DELIVERY CY24 (All Occurrences Comparison Report from OVR Stats page)	Q3
Birth Trauma	-
CPOE issue	-
C-Section with no first assist	-
Emergency C-Section > 30 min	1
Fetal Distress	3
Fetal/Maternal Demise	2
Induction Bishop <6	-
Infant d/c to wrong person	-
Instrument Related Injury	-
Maternal complications	3
Maternal Transfer To Higher Level Of Care	4
Meconium Aspiration	-
Meconium staining	-
Neonatal complications - Admit Mother/Baby	-
Neonatal complications - Admit NICU	26
Neonatal complications - Apgar <5 @5 min	2
Neonatal complications - Impaired Skin Integrity	-
Neonatal complications - IV Infiltrate	-
OB Alert	1
Other	12
Postpartum Hemorrhage	28
Return To Ldr (Labor Delivery Room)	2
RN Attended Delivery	-
RN Unattended Delivery	-
Shoulder Dystosia	7
Sponge/Needle/Instrument Issues	-
Sterile field contaminated	-
Surgical Count	-
Unplanned Procedure	1
OB Delivery Total	92

OB DELIVERY Q3 CY24:

There were a total of 92 OB Delivery incidents for Q3 with an increase of 20% from Q2.

Shoulder dystocia and postpartum hemorrhage with QBL>1000 are sent to quality for review and to ensure proper quality of care.

HAPIs CY24 Browse - Binoculars - BHMC HAPIs and HAPI Comp Rpt by Inj Type for injury type breakdown	Q3
Pressure Injury - Acquired	12

Injury Type	3rd Quarter
Decubitus - Stage I	0
Decubitus - Stage II	1
Decubitus - Stage III	1
Decubitus - Stage IV	
Deep Tissue Injury	10
Unstageable Ulcers	
Grand Total	12

HAPIS Q3 CY24:

There were 12 Hospital Acquired Pressure Injuries for Q3 which is a 52% from Q2.

Out of the 12 HAPIs 1 were reportable.

MEDICATION VARIANCES (All Occurrences Comparison Report on OVR Stats page)	Q3
Contraindication	-
Control Drug Discrepancy Investigation	5
Control Drug Charting	-
Control Drug Discrepancy-count	-
Control Drug Diversion/Suspicion	-
CPOE issue	-
Delayed dose	12
eMAR - Transcription/Procedure	1
Expired Medication	3
Extra Dose	1
Hoarding Medications For Later Use	-
Illegible Order	-
Improper Monitoring	2
Labeling Error	3
Missing/Lost Medication	4
Omitted dose	5
Other	15
Prescriber Error	-
Pyxis Count Discrepancy	1
Pyxis False Stockout	-
Pyxis Miss Fill	2
Reconciliation	-
Return Bin Process Error	1
Scan Failed	-
Self-Medicating	-
Unordered Drug	2
Unsecured Medication	2
Wrong Concentration	1
Wrong dosage form	-
Wrong dose	4
Wrong Drug or IV Fluid	4
Wrong frequency or rate	1
Wrong patient	2
Wrong Route	-
Wrong time	-
Med Variance Total	71

MEDICATION VARIANCES Q3 CY23:

There was a total of 71 medication variances for Q3 with an increase of 7.57% from Q2.

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 CY24 (All Occurrences Comparison Report from OVR Stats page)	Q3
Dermatological	1
Miscellaneous	1
ADR Total	2

ADR CY24:

Total of 2 ADR in Q3.

Trauma patient who developed a rash after IV contrast was given. Allergy added to their profile

SURGERY RELATED ISSUES CY24 (All Occurrences Comparison Report from OVR Stats page)	Q3
Anesthesia Complication	-
Consent Issues	17
CPOE issue	-
Surgery Delay	3
Extubation/Intubation	-
Puncture or Laceration	-
Retained Foreign Body	-
Surgery/Procedure Cancelled	3
Surgical Complication	3
Sponge/Needle/Instrument Issues	9
Sterile field contaminated	4
Surgical Count	20
Incorrect information on patient's chart	-
Positioning Issues	1
Surgical site marked incorrectly	1
Tooth Damaged/Dislodged	1
Unplanned Surgery	6
Unplanned Return to OR	3
Wrong Patient	-
Wrong Procedure	-
Wrong Site	-
Surgery Total	71

SURGERY RELATED ISSUES Q3 CY24:

There was a total of 71 surgery related issues for Q3 with a 8.97% decrease from Q2.

Consent Issues Trends: 9 were trauma related and 4 were clerical

Surgical Count - No retained foreign body, missing count process followed. 4 were intentionally left in the patient

SECURITY CY24 (All Occurrences Comparison Report from OVR Stats page)	Q3
Abduction	-
Access control	-
Aggressive behavior	12
Armed Intruder	-
Arrest	1
Assault/Battery	11
Break-in	1
Code Black	-
Code Elopement	2
Code Pink	-
Code Strong	-
Contraband	5
Criminal Event	-
Elopement -Involuntary admit	-
Elopement -Voluntary admit	4
Property Damaged/Missing	19
Rapid Response Team - Visitor	-
Security Assistance	43
Security Presence Requested	84
Security Transport	-
Smoking Issues	1
Threat of violence	26
Trespass	1
Vehicle Accident	3
Verbal Abuse	24
Security Total	237

SECURITY Q3 CY24:

There was a total of 237 security incidents for Q3 with a 5.57% decrease in security occurrences from Q2.

94 (39.66%) of security incidents were related to BH and Psych ED patients.

SAFETY (All Occurrences Comparison Report from OVR Stats page)	Q3
Biohazard Exposure	2
Code Red	6
Code Spill - Chemical	1
Code Spill - Chemo	-
Electrical Hazard	-
Elevator entrapment	-
False Alarm	-
Fire/Smoke/Drill	-
Gas/Vapor Exposure	-
Safety Hazard	12
Sharps Exposure	2
Safety - Other (no category)	-
Safety Total	23

SAFETY Q3 CY24:

There was a total of 23 Safety incidents for Q3 with 42.5% increase/decrease in safety occurrences from Q2.

Highest category for incidents were related to Safety Hazards - no trend identified

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.)

Neonatal Death - 20 y/o G1P0, 40.1 weeks came in for induction of labor. No medical history, surgical hx, appendectomy 2021, use marijuana. Vaginal exam- 2-3cm/50, contracting irregularly. Pt was 40 weeks – Patient laboring for 16 hrs before c-section was called. When infant was delivered – baby was floppy and CPR was initiated. Infant pronounced at 1929.

CCU Fall with Injury - The patient presented to the ER as a Level II Trauma after being found down in his home. CT of the brain showed a small R frontal scalp hematoma; otherwise, no abnormality. Also noted elevated ethanol level and low sodium. Admitted to CCU. Patient was agitated, trying to get out of bed; fall protocol implemented, condom cath placed, sitter requested, PRN Haldol orders received, bed alarm on. He was then found face down on the floor by CVICU charge nurse. A STAT CT of the brain showed interval development of 6 MM hemorrhagic contusion in the anterior R frontal lobe. No extra-axial hemorrhage, no facial bone fracture.

Baker Acted Patient - 18-year-old female was observe brought to the ER because of a the patient had an said the foreign body in her a the vagina. Patient was seen and evaluated in the ER. By the ER physician patient had removal of the foreign body. Patient stated that she had swallowed a battery. Multiple times throughout this patients admission she was able to obtain items and insert them in her oracies despite interventions the hospital had put in place to attempt to prevent this behavior.

Delay In Stroke Alert - Patient with a long history of hypertension, hyperlipidemia, coronary heart disease and diabetes. She presented to the ED with 2 days of worsening weakness. After admission she began to have slurred speech; imaging revealed a left MCA distribution stroke. The patient was intubated, stroke became hemorrhagic. Missed opportunities to call Stroke Alert.

Code Blue - Patient admitted to 4NT on 9/5 for SOB – she arrived to the floor with a laryngeal tube that was placed in May at the University of Miami. The patient remained stable throughout the day until around 7:30pm. ANM, noticed the patient at the doorway calling her over. It was immediately recognized that the patient's laryngeal tube had become dislodged. Primary RN, Respiratory and ANM were at the bedside and attempting to reinsert the laryngeal tube – which was unsuccessful. RR was called for additional assistance. Patient went into PEA and a code blue was subsequently called. ACLS initiated and patient coded for 4 minutes before ROSC was achieved. Patient transferred to ICU for closer observation.