BHIP RISK MANAGEMENT QUARTERLY REPORT QUARTER 3 CY 24

Occurrence Category CY24	Q3	%
Patient Care Issues	189	41%
Security	122	26%
Surgery Issues	42	9%
Falls	33	7%
Delay	27	6%
Safety	14	3%
Medication Variance	12	3%
Lab	10	2%
Adverse Drug Reaction	5	1%
Skin and Wound	5	1%
Patient Rights	2	0%
HIPAA PHI	2	0%
Infection Control	1	0%
Grand Total	**464**	**100%**

OCCURRENCE CATEGORY CY24:

Patient care issues and security issues remain our top event reports. We have seen a steady increase in event reporting through continued education of staff and leadership.

Incident Reports:
July - 137
August - 161
September - 166

Inpatient Falls by SubCategory CY24	Q3
Found on floor	13
From Bed	4
While Ambulating	4
Patient States	3
Eased to floor by employee	3
Slip	3
From Chair	1
From Toilet	1
Trip	1
Grand Total	**33**

INPATIENT FALLS BY CATEGORY CY24:

Significant number of falls throughout the facility in Q3. Fall committee was re-established. Nursing leadership reingaged in ensuring the safety of our patients.

Falls with Injury:
Fall with laceraction to the back of the head. Imaging negative. No intervention required.
Fall with skin tear. Imaging negative. No intervention required.
Fall with laceration to the chin. Sutures required. Imaging negative.
Fall with abrasion to forehead. Imaging negative. No

HAPIs CY24	Q3
Skin/Wound - Present on admit	3
Pressure Injury - Acquired	1
Pressure Injury - On Admission	1
Grand Total	5

HAPIS CY24:

1 pressure injury acquired (DTI) during patient stay. Pressure injury was noted after an extended OR procedure.

July - 1 Acquired
August - 1 POA
September - 3 POA

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MEDICATION VARIANCES CY24	Q3
Wrong Drug or IV Fluid	2
Extra Dose	2
Unsecured Medication	2
Omitted dose	1
Prescriber Error	1
Pyxis Miss Fill	1
Wrong dose	1
Wrong patient	1
Wrong time	1
Grand Total	**12**

MEDICATION VARIANCES CY24:

All medication variances reviewed with Pharmacy and nursing leadership during Patient Experience Key Group.

Wrong Drugs:

Patient stated he was on 50mg hydroxyzine vs. 50mg hydralazine.

ADR CY24	Q3
Gastrointestinal	4
Allergy	1
Grand Total	**5**

ADR CY24:

Ancef given in preop area is the cause of the gastrointestinal ADR's. Unknown allergy to CT contrast media. Patient reaction of itching and hives. IV benadryl administered to patient with positive results.

SURGERY RELATED ISSUES CY24	Q3
Surgery/Procedure Cancelled	12
Surgical Complication	7
Consent Issues	6
Anesthesia Complication	5
Surgery Delay	**4**
Unplanned Return to OR	**4**
Sponge/Needle/Instrument Issues	**2**
Sterile field contaminated	**1**
Puncture or Laceration	**1**
Grand Total	**42**

SURGERY RELATED ISSUES CY24:

Surgical related issues reviewed in detail in PCKG.

Unplanned return to OR:
Revision of AV Fistula creation.
I&D with component exchange 16 days post surgery
Gastrectomy sleeve with return for bleeding control
Abdominal abscess.

July - 17
August - 15
September - 10

SECURITY CY24	Q3
Security Assistance	34
Security Presence Requested	29
Aggressive behavior	19
Contraband	10
Assault/Battery	8
Property Damaged/Missing	5
Verbal Abuse	4
Security Transport	4
Trespass	3
Smoking Issues	2
Elopement -Voluntary admit (persons admitted on their own accord/will; non-vulnerable individuals)	2
Threat of violence	1
Criminal Event	1
Grand Total	**122**

SECURITY CY24:

51.63% (63 of 122) reportsof security calls were for Security Assistance/Security Presence Requested.

8 Assualt/Battery reports. 1 was a dog bit from a patient's stated service dog in the ED.

Creation and implementation of WPV committee along with a Security Task Force in late Q3. Further development of programs in Q4 and Q1 2025.

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SAFETY CY24	Q3
Safety Hazard	14
Grand Total	**14**

SAFETY CY24:

1 needle stick

Safety hazards are being reviewed for appropriate classification and reclassification as necessary.

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 15 - August 2024:
58yo female scheduled for bilateral capsulotomy with bilateral breast implant exchange, breast lift, and fat transfer from thighs to face/neck area in the outpatient surgery center. Patient was known to the surgeon and known to have had multiple cosmetic procedures in the past. Patient was noticed to posture upon extubation. Clinical staff reported concerns and observations to the anesthesiologist and surgeon who requested to wait 30 minutes and reassess. At 30 minutes, patient was reassessed and clinical staff escalated to anesthesiologist and surgeon. Staff was instructed to wait an additional 30 minutes. When instructed to wait again, the staff requested that 9-1-1 be called for a stroke alert based on the patient's presentation and physical observations. Patient was transfered to Holy Cross which is the closest comprehensive stroke center for intervention and further treatment. Patient passed away 8/30/2024.

RCA Completed - September 2024:
71yo male admitted to BHIP Med/Surg 5th floor for encephalopathy, pedal edema, hydropneumothorax, lung mass, and anemia. Patient home medications included hyrdolozine 50mg and hyrdoxozine 10mg. Upon entering the hospital, the patient told the nurse he takes hyroxozine 50mg. Upon admission, patient's EKG showed wide QT interval. Patient was on telemetry monitor where the monitor showed V-Fib but was only showing one lead. Telemetry tech called the charge desk where she informed the unit secretary to have someone go check the patient and the leads. Telemetry tech was informed that the nurse was in another room giving report. A short time later, a nurse was sitting at the nursing station and heard the alarm for V Fib and went into the room to check the patient. Patient had no pulse and the nurse immediately began CPR.

Code 15 from January 2024 Discovered and Reported in September 2024:
43yo male patient presented to BHIP for behavioral health treatment and stabilization on January 1, 2024. Patient was observed intentionally hitting his head against a wall within the unit. Patient complained of severe headaches after hitting his head on the wall. Minimal information regarding this case was available. Upon further investigation, it was learned that the patient died at BHN on January 23, 2024. Case was not reported to AHCA.

Implemented bi-weekly meetings with compliance to review current issues and begin trending concerns.
Rounding with staff and leadership to introduce myself and set expectations for HAS and reporting of incidents.