AMBULATORY RISK MANAGEMENT QUARTERLY REPORT QUARTER 3 CY23

Occurrence Category CY24 (BHP, BHPO, CDTC,BHW, BHC)	Q3	%
PATCARE	26	26%
SECURITY	27	27%
MEDICATION	14	14%
FALL	9	9%
SAFETY	11	11%
HIPAA/PHI	7	7%
LAB	1	1%
PPID	3	3%
SKIN/WOUND	1	1%
OB DELIVERY	1	1%
PATIENT RIGHTS	1	1%
Grand Total	101	100%

TOTAL OCCURRENCES CY24 Q3:

More than half of the occurrences were reported by BHP (58%), followed by BHPO with 17%, Corporate 13%, CDTC 6% and Weston 5%. Increased number of Weston occurrences reported.
Total number of reports decreased 2% when compared to second quarter.
Risk management continues to promote patient safety and occurrence variance reporting.

PATIENT CARE CY24	Q3
TRANSFER TO HIGHER LEVEL OF CARE	8
MEDICAL RECORDS	1
BAKER ACT	3
DISRUPTIVE BEHAVIOR	2
PATIENT NONCOMPLIANCE	1
ACTIVITY INJURY	1
RAPID RESPONSE	5
DOCUMENTATION ISSUE	2
SEXUAL MISCONDUCT	1
IV INFILTRATION	1
PROCEDURE COMPLICATION	1
Total	26

PATIENT CARE:

Reported by BHP, CDTC, BHPO and Weston.
Appropriate steps followed for the Baker Act events.
Child hit head unrelated to care at CDTC.
Allegations received related to employee sexual misconduct were not able to be substantiated. HR involved.
IV MRI contrast infiltration, no harm.
Procedure complication related to patient unable to complete MRI of breast ordered by oncologist due to pain.

SECURITY CY24	Q3
AGGRESSIVE BEHAVIOR	6
VEHICLE ACCIDENT	7
ACCESS CONTROL	5
SECURITY PRESENCE REQUESTED	3
TRESSPASS	1
PROPERTY DAMAGED/MISSING	3
CRIMINAL EVENT	1
ASSAULT	1
Total	27

SECURITY:

First notice of event completed for MVA involving employee's car hitting pedestrian at CDTC's parking lot exit. Extra mirror installed. First notice completed for tenant alleged car damage due to malfunctioning gate at BHCS physician parking. Gate working properly.
Claims and insurance notified of two MVAs involving BH vehicles.
Falsified prescriptions received by four different outside pharmacies, same patient, not a patient of alleged ordering physician.

MEDICATION VARIANCES CY24	Q3
OTHER	3
WRONG FREQUENCY	2
WRONG DOSE	2
DELAYED DOSE	2
EXTRA DOSE	1
WRONG PATIENT	1
WRONG DRUG	1
PRESCRIBER ERROR	1
EXPIRED MEDICATION	1
Total	14

MEDICATION VARIANCES:

All from BHP.
Three near misses caught by pharmacy.
Ordering providers and patients notified of errors.
Pharmacy errors discussed at pharmacy huddles.
Delayed treatments for chlamydia. LPN assigned daily for pool messages review.
Back to School Vaccination Event discussed below.
Vaccination related occurrences at CEB Peds addressed by leadership.

FALL CY24	Q3
WHILE AMBULATING	2
PATIENT STATES	1
FOUND ON FLOOR	2
TRIP	3
FROM INFANT CARRIER	1
Total	9

FALL:

Six patient falls, two employee and one visitor.
Reported by BHP, BHPO, CDTC, Corporate and IC.
Baby fall from car seat with parent at waiting area, not strapped, no injuries.
Visitor fall over speed bump with mouth cut, transferred to ED, no other injuries.
Facilities painted ortho building curb at parking lot yellow to alert pedestrians.

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SAFETY CY24	Q3
SAFETY HAZARD	5
FALSE ALARM	2
CODE RED	1
SHARPS EXPOSURE	1
GAS/VAPOR EXPOSURE	2
Total	11

SAFETY:

Code red called due to suspected fire alarm, confusion with facilities work.
Safety hazards due to CCC emergency door found unlocked several times without alarm notification. Alarm will be connected to electricity instead due to frequent battery replacements and key lock will be changed.
Patient presented to dental appointment carrying a gun which was placed inside his car upon request.
Employee reported exposure to poor air quality at work. Employee health notified. Air quality control assessment and carpet cleaning completed. Air quality within guidelines.

HIPAA/PHI CY24	Q3
PATIENT PRIVACY COMPLAINT	1
UNAUTHORIZED ACCESS	2
UNAUTHORIZED DISCLOSURE	2
IMPERMISSIBLE DISCLOSURE/VERBAL	1
SECURITY BREACH	1
Total	7

HIPAA/PHI:

Reported by BHP, BHPO and Corporate.
Further investigated by the privacy team.
Two breaches per privacy.
Unauthorized employee access to MR, resigned.
Security breach from business associate Healthfund Solutions impacting BH patients, OCR notified.

LAB CY24	Q3
DELAYED RESULT	1
Total	1

LAB:

BH currier forgot specimens on the counter. All labs able to be processed.

PPID CY24	Q3
WRONG PATIENT	2
WRONG INFORMATION	1
Total	3

PPID:

Trend noted with specific employee discussed with leadership and HR.
Corrections made to patient charts.

SKIN/WOUND CY24	Q3
ACQUIRED	1
Total	1

SKIN/WOUND:

Patient hit head on cabinet, small abrasion.

OB DELIVERY CY24	Q3
FETAL DEMISE	1
Total	1

OB DELIVERY:

Fetal demise at CEB Prenatal. Investigation below.

PATIENT RIGHTS 24	Q3
REFUSAL	1
Total	1

PATIENT RIGHTS:

Patient non-compliance with treatments ordered.

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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.)

August

When pharmacy went to review stats on 8/15/24 for the CEB Back to School Jamboree event that took place on 8/3/24, it was discovered that there was no documentation in Cerner for any of the vaccines administered that day. There was nothing reported in Health Analytics or in Florida SHOTS.
All patients were registered, and an encounter/account was created for each patient.
Physical exams were documented by the MDs and/or APRNs on Florida Health School Entry Health Exam form.
The two locations saw almost the same number of patients but had different processes for ordering, administering and documenting the immunizations.
Pompano had less employees working during the event than CEB.
As of 8/21/24 there was no documentation in Cerner that the vaccines were administered. Pharmacy reviewed all vials in the container and observed that the same vaccine type had vials with more than one lot number for at least 4 different vaccines.
At Pompano Pediatrics, all patients were seen by a provider and had a physical exam. The APRN saw the patients that only needed a physical and the MD saw all the patients who needed immunizations. The physician ordered all the vaccines in Cerner. This generated a task for the MAs who were administering it. The two MAs responsible for vaccine administration documented all required information in Cerner after each administration, as it is done during regular clinic visits, according to policy BHP-014-235 - Medication Administration, and as instructed during annual competencies. Cerner documentation crosses over to Florida SHOTS. These MAs did not participate in planning meetings but relied on experiences from previous events.
The 6 records reviewed for CEB only had the consent form, no other documentation.
Neither location had physical forms scanned into patient records. CEB still had all School Entry Health Exam forms, but Pompano only had the forms for the patients who were seen by the APRN. Copies of the form for the patients seen by the MD were not performed because the staff did not have access to a copier at that area of the clinic.
Care provided by Broward Health and its employees, including medication ordering, administration and documentation, must be done according to standards of practice and BHP policy, and be part of patient medical records.
CEB leadership must revise planning strategies for future events.
The MA responsible for vaccine documentation entered all required documentation into Florida SHOTS by 8/20/24 but there was no way to know what vial was used for each patient or what site was the vaccine administered.
On 8/21/24, the nurse coordinator manually uploaded the immunization records from Florida SHOTS into Cerner for all patients. The information found in Cerner only shows the vaccine administration date. It does not provide information that the vaccines were administered by a Broward Health employee or contains any information about lot numbers or expiration dates.
The team participating at 8/20/24 and 8/21/24 meetings believed that there were system failures that contributed to the event, lack of accountability for assigned responsibilities and below standard employee performance.
Director of operations for CEB and nurse manager will provide re-education on medication ordering, administration, and documentation, as well as activation of chain of command when tasks cannot be completed as planned or when processes are outside standards, to all CEB Pediatrics staff, including providers. Note that this had already taken place this year at CEB Pediatrics as action plan for a medication variance event.
Director of operations for CEB will be responsible for decisions regarding supervisory notes or other appropriate corrective actions related to employee performance.
Physician decisions must be reviewed by a medical director or designee. Recommendation is to discuss what constitutes an acceptable provider immunization order.
BHP pharmacy manager will share the list of all vaccine lots administered at CEB on 8/3/24 with the medication buyer for future reference in case of related recall notice.
Director of operations for CEB and BHP Administrative director of operations will ensure that best practices used at Pompano Pediatrics are applied to all events carried out by CEB after 8/21/24.
The Director of operations for CEB will have all School Entry Health Exam forms scanned into patient charts.

September

24-year-old patient 29 weeks pregnant, presented to Cora E. Braynon Prenatal for a fetal anatomy US around 8:15 am. During scan, the tech noted that the FHR was 132 (within normal) but measurements showed growth restrictions (4-5 weeks behind) and brain abnormalities. The tech followed protocol and did a BPP for which the patient scored 8/8 and dopplers which were irregular, absent and reversal flow. The tech advised the patient to wait. The MFM physician was contacted at 9:47am and she advised the tech that she was headed to the office, and she would rescan the patient. MFM arrived and began to rescan the patient at 10:32am and she did not see a heartbeat and noted that there was a fetal demise. 911 was called at 10:38am. As the patient was waiting on 911, the MFM discussed all ultrasound findings with the patient.
Patient was transferred to BHMC L&D, and a vaginal delivery was induced.
Case reviewed by a second MFM physician. An early diagnosis was not possible as patient presented late for prenatal, around 20 weeks. If patient had an earlier scan, IUGR would have been diagnosed and monitoring would have started. Based on the US, the fetus was affected by a congenital anomaly/genetic syndrome that can explain the IUGR. Reviewer did not identify significant delays in care. Reverse flow is an ominous sign that requires hospital admission but not an emergency such as for example fetal bradycardia.
Case reviewer recommended referring patients for US at BHMC if the waiting times at CEB are greater than 2-3 weeks.
RCA meeting was conducted on 9/30/24 with risk manager, AVP women and children services, MFM physician involved, US tech involved, prenatal supervisor and pharmacy resident.
Team concluded that this was an unexpected event and that US findings would justify transfer to hospital for further monitoring but were not a reason to handle the situation as an emergency.
Around July 2024, prenatal was down to one ultrasound tech until the 2nd week of August. As the patient did not have insurance at the time, she was not able to have ultrasound done at the hospital. Currently, prenatal has all 4 techs in place and wait times are approximately 2-3 weeks. Stat US are accommodated and performed on same day.