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2019 Sentinel Events Summary Report

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State Board of Health Meeting
Department of Health and Human Services, Office of Analytics
and
Division of Public and Behavioral Health, Office of Public Health Investigations and Epidemiology, Sentinel Event Registry

June 5, 2020 - Final

Agenda

- Sentinel event definition
- SB457 (changes and implementation)
- Who should report sentinel events?
- Data collection methods
- Data analysis results
- Plans and goals
- Conclusion

Unforeseen Circumstances

- The 2019 Novel Coronavirus (COVID-19) pandemic necessitated SER adjustments.
- It is expected that once COVID-19 work loads diminish and SB457 has been implemented, the program will return to normal levels of filing participation and data quality enforcement.
- This year's report reflects these unusual conditions.

Definition

- Assembly Bill (AB28), effective 10/1/2013
- Defined as a serious reportable event included in Appendix A of *"Serious Reportable Events in Healthcare—2011 Update: A Consensus Report."*

  - serious, largely preventable, and harmful clinical events that should 'never' happen -
- Published by the National Quality Forum (NRS 439.830).
  - *Updated in 2013 to exclude healthcare acquired infections, HAI, reporting. All data included in this report has qualified per the definition of sentinel event in effect for 2017.*
- Reporting has been conducted in Nevada since 2000, with force of statute since 2011.

Definition Expanded

- Senate Bill (SB457), effective 10/1/2019
- Further defines reportable events to include non natural deaths.
- Expands list of facilities reporting to the definition of Health Care facility.
- 1,533 health care facilities now report to the SER.
- Notices to most health care facilities sent on 1/2/2020.
- Currently 441 facilities are actively participating.

Who Should Report? (Part 1)

- **NRS 439.805 "Medical facility" defined.**

1. A hospital, as that term is defined in NRS 449.012 and 449.0151;

2. An obstetric center, as that term is defined in NRS 449.0151 and 449.0155;

3. A surgical center for ambulatory patients, as that term is defined in NRS 449.0151 and 449.019; and

4. An independent center for emergency medical care, as that term is defined in NRS 449.013 and 449.0151.

Who Should Report? (Pre SB457)

- **Medical Facility SER Participation – Sentinel Events Registry 2019**

Facility Type Defined	Facility Type Code	Facility Count	Count of Facility Types in CY 2019 that filed 1 or more events	Count of Facility Types in CY 2019 that filed the Annual Summary Report
Surgical center for ambulatory patients	ASC	74	9	24
Hospital	HOS	54	32	33
Rural hospital	RUH	14	9	10
Total		142	50	67

Who Should Report? (Part 2)

- **NRS 439.803 "Health facility" defined.** "Health facility" means:
- 1. Any facility licensed by the Division pursuant to chapter 449 of NRS; and
- 2. A home operated by a provider of community-based living arrangement services, as defined in NRS 449.0026.
- (Added to NRS by 2019, 1666)

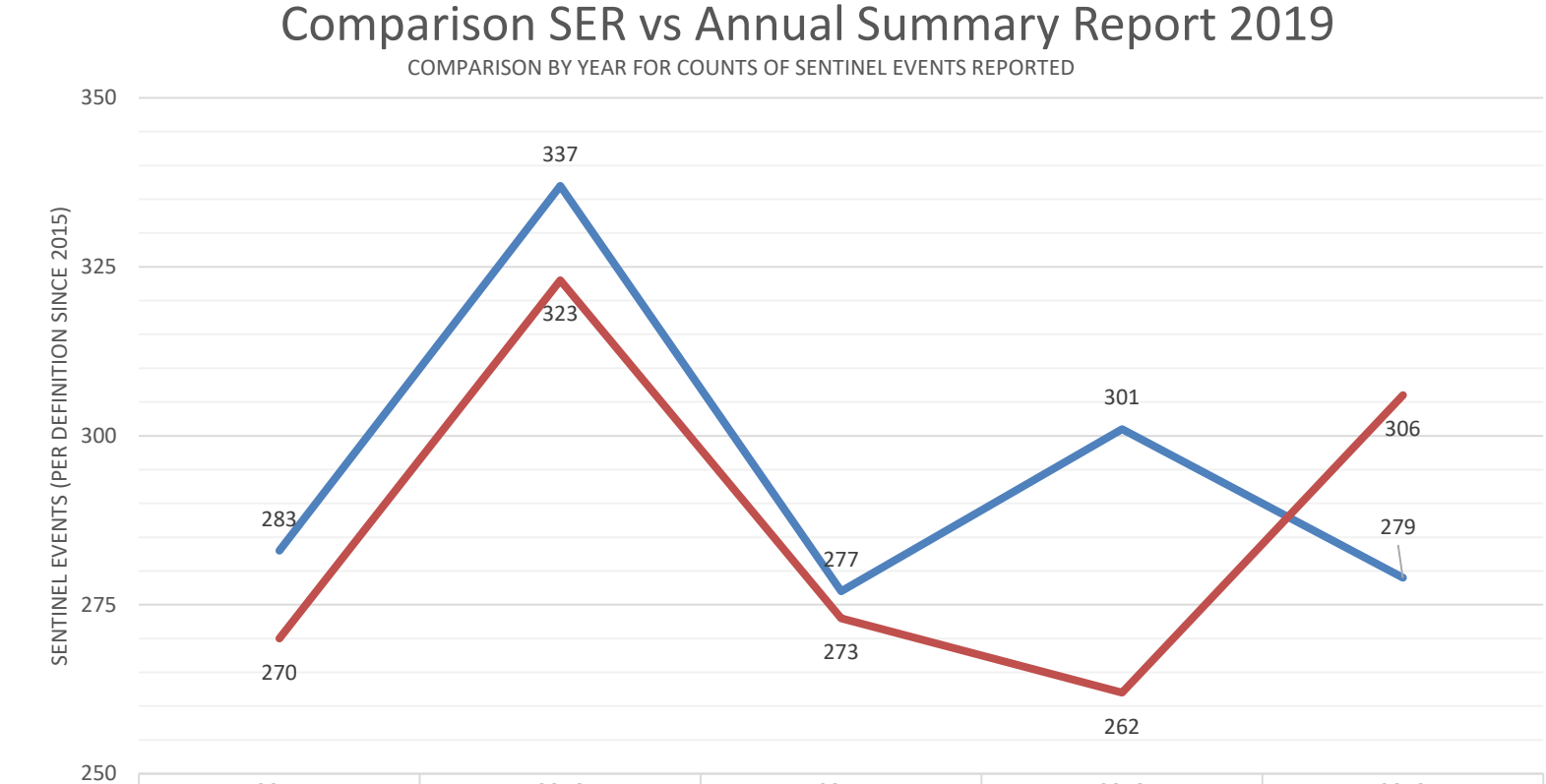
Who Should Report? (SB457)

Facility Code	Facility Type Description
HHA	AGENCY TO PROVIDE NURSING IN THE HOME
HBR	AGENCY TO PROVIDE NURSING IN THE HOME - BRANCH OFFICE
HSB	AGENCY TO PROVIDE NURSING IN THE HOME - SUB UNIT
PCS	AGENCY TO PROVIDE PERSONAL CARE SERVICES IN THE HOME
BPR	BUSINESS THAT PROVIDES REFERRALS TO RFFG
CTC	COMMUNITY TRIAGE CENTER
HFS	FACILITY FOR HOSPICE CARE
ICF	FACILITY FOR INTERMEDIATE CARE
IMR	FACILITY FOR INTERMEDIATE CARE/IID
MDX	FACILITY FOR MODIFIED MEDICAL DETOXIFICATION
SNF	FACILITY FOR SKILLED NURSING
ADC	FACILITY FOR THE CARE OF ADULTS DURING THE DAY
ADA	FACILITY FOR THE TREATMENT OF ABUSE OF ALCOHOL OR DRUGS
ESRD	FACILITY FOR THE TREATMENT OF IRREVERSIBLE RENAL DISEASE
TLF	FACILITY FOR TRANSITIONAL LIVING OF RELEASED OFFENDERS
NTC	FACILITY FOR TREATMENT WITH NARCOTICS
HWH	HALF-WAY HOUSE FOR RECOVERING ALCOHOL AND DRUG ABUSERS
HIC	HOME FOR INDIVIDUAL RESIDENTIAL CARE
HPC	HOSPICE CARE - PROGRAM OF CARE
HOS	HOSPITAL
ICE	INDEPENDENT CENTER FOR EMERGENCY MEDICAL CARE
NSP	NURSING POOL
OPF	OUTPATIENT FACILITY
PCO	PERSONAL CARE AGENCY THAT IS ALSO ISO CERTIFIED
PRTF	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
AGC	RESIDENTIAL FACILITY FOR GROUPS
RHC	RURAL CLINIC
RUH	RURAL HOSPITAL
SFD	SKILLED NURSING FACILITY DISTINCT PART OF HOSPITAL
ASC	SURGICAL CENTER FOR AMBULATORY PATIENTS

Data Collection Methods

- Event Report forms:
  - Part 1 Initial report to sentinel events registry and
  - Part 2 Root Cause Analysis results
- Summary Annual Report forms: Sentinel event report summary forms and patient safety committee forms were due on March 1, 2020. (All reporting facilities required to file)
- Updated standardized list of reportable events including NQF reference and greater specificity

Sentinel Events Reporting Comparison



	2015	2016	2017	2018	2019
ARSER	283	337	277	301	279
SER	270	323	273	262	306

Sentinel Events by Type in 2019

(from Annual Summary Report Form)

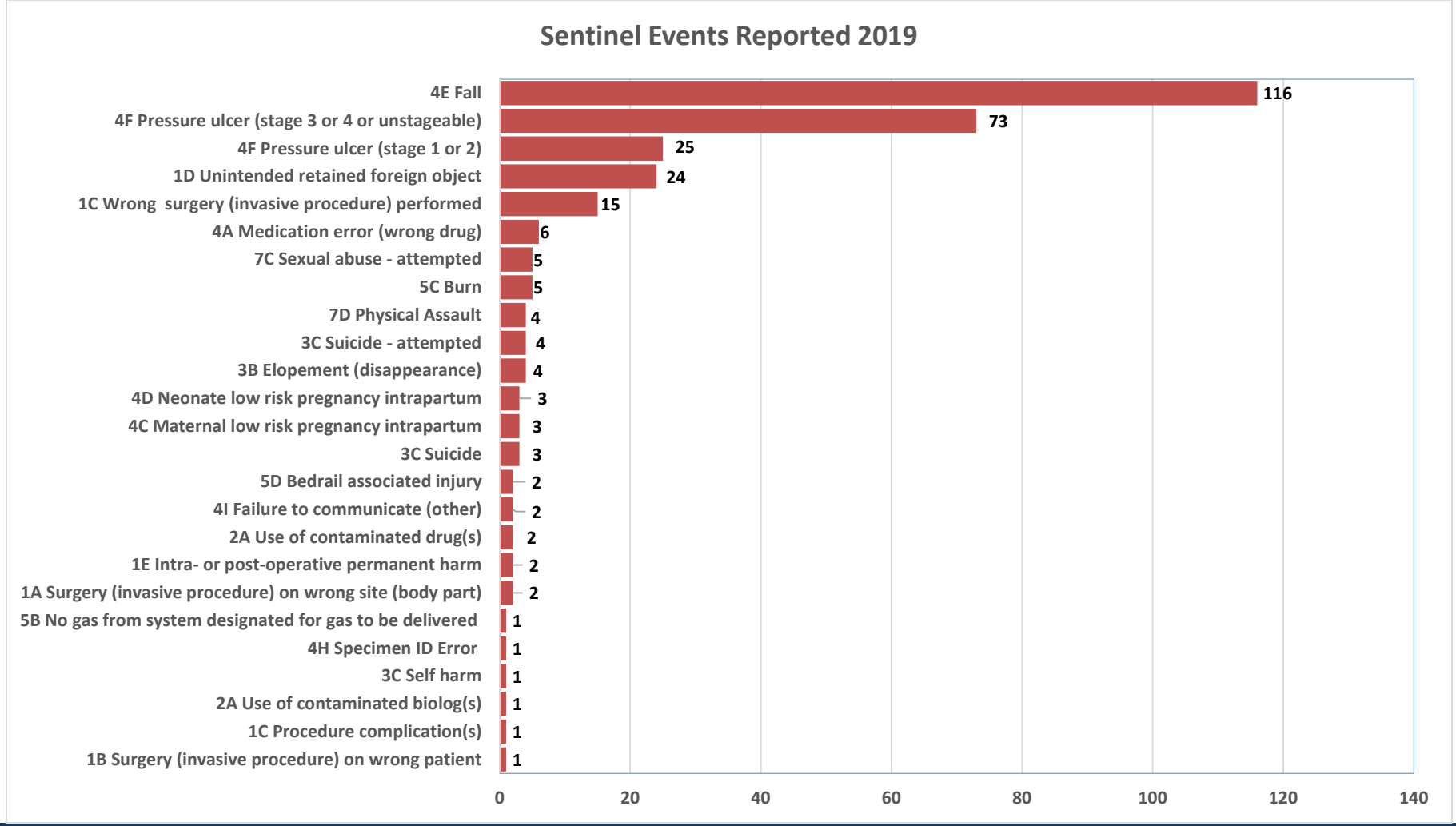
Event Types and Totals

For the calendar year 2019, one hundred forty-two (142) facilities were expected to file. Sixty seven (67) facilities have completed the annual summary sentinel events report (ASRSER), uploaded a copy of their Patient Safety Plan (PSP), and updated the designated Patient Safety Committee (PSC) reporter's contact information, even if no sentinel event occurred. Seventy five (75) facilities had not filed their ASRSER. The end of the business day on March 1, 2020 **(NRS439.843,) the** deadline was not enforced due to COVID-19 and other issues.

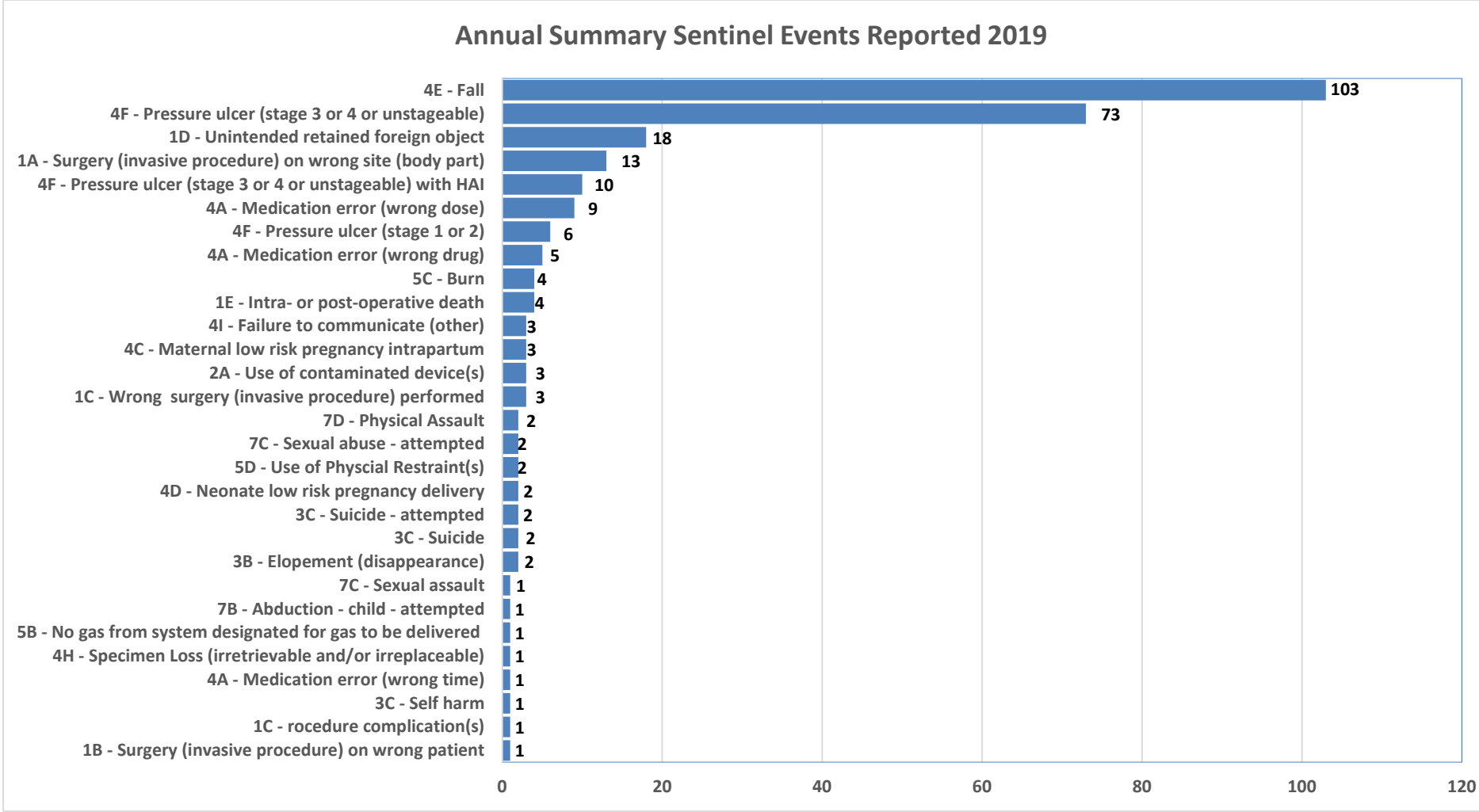
Facility Type	Facility Type Defined	Count of Facility Type	Count of Reported Events - Current Definition
ASC	Surgical center for ambulatory patients	24	19
HOS	Hospital	33	244
RUH	Rural Hospital	10	16
ALL	Count of facilities and events	67	279
Other	Not Required to Report, yet did report	30	9

Sentinel Events by Type in 2019

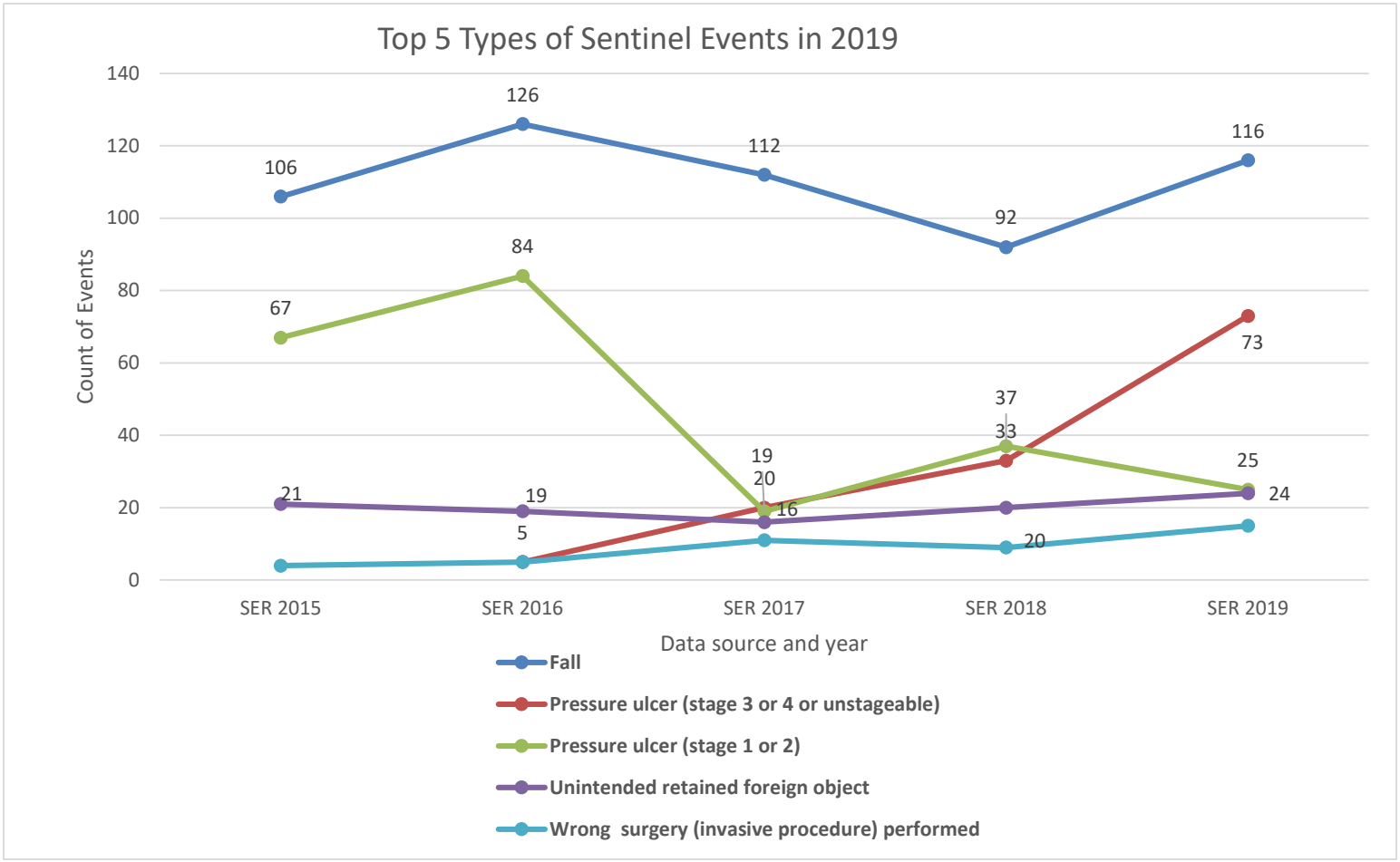
(from events Reporting Form)



Sentinel Events by Type in 2019 (from Annual Summary Report Form)



Top 5 Types of Sentinel Events



Fall

Pressure Ulcer (3 or 4)

Pressure Ulcer (1 or 2)

Retained Foreign Object

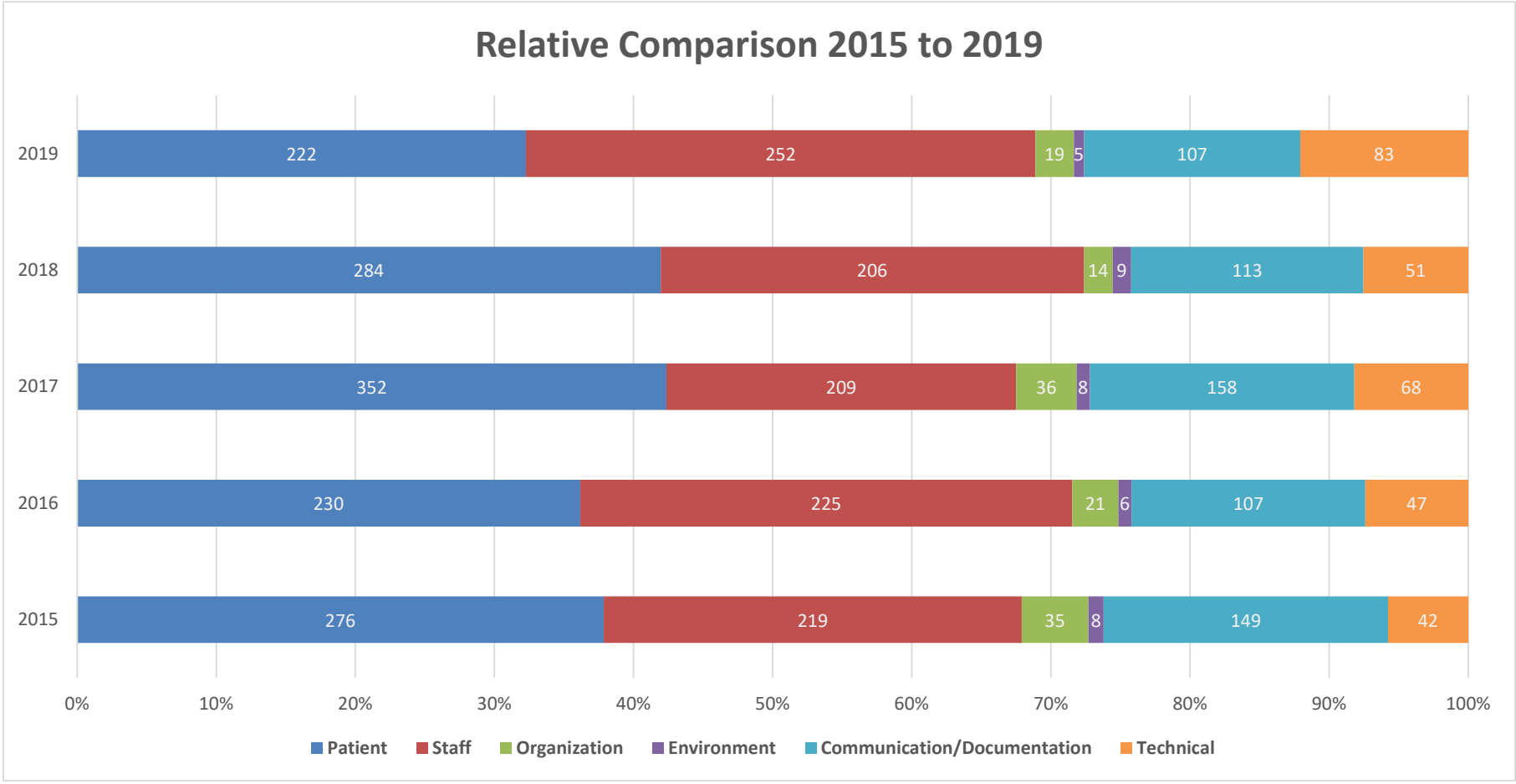
Surgery Wrong Procedure

The ‘where’ of Sentinel Events Occurrence in 2019

(up to 4 can be selected)

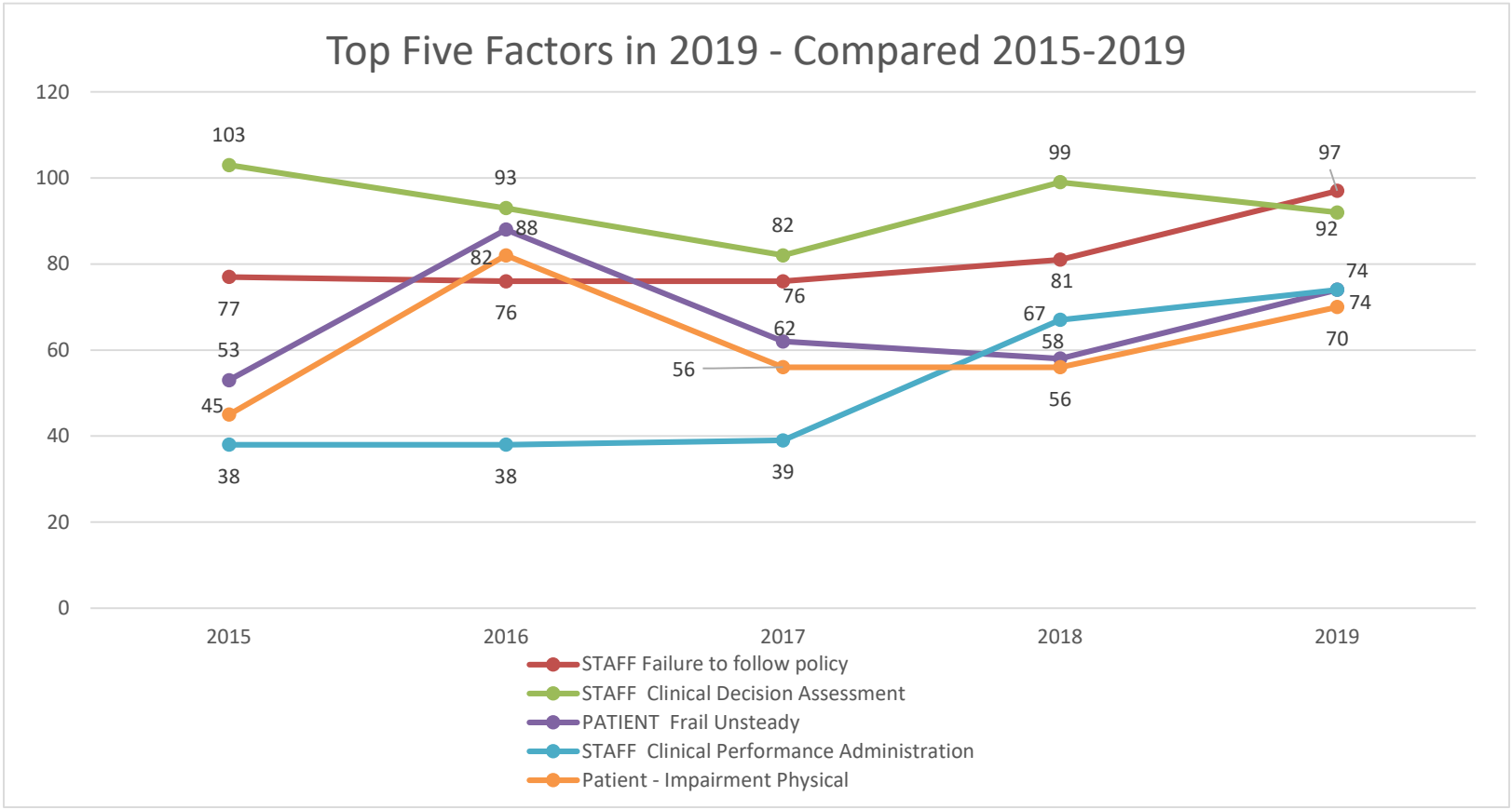
Department/Location	Count	Percent
Medical/surgical	83	28
Intensive/critical care	39	13.2
Intermediate care	28	9.5
Emergency department	25	8.4
Inpatient surgery	21	7.1
Ancillary other	11	3.7
IP Rehabilitation	10	3.4
Ancillary other	9	3
Long term care	8	2.7
Psychiatry/behavioral health/geropsychiatry	8	2.7
Labor/delivery	7	2.4
Nursing/skilled nursing	7	2.4
Anesthesia/PACU	5	1.7
Postpartum	5	1.7
Imaging	4	1.4
Pulmonary/respiratory	4	1.4
Cardiac catheterization suite	3	1
Ambulatory Care	3	1
Pediatrics Intensive Care	3	1
Pediatrics	3	1
Endoscopy	2	0.7
Neonatel Level 3	2	0.7
Observational/clinical decision unit	2	0.7
Antepartum	1	0.3
Dialysis	1	0.3
Laboratory	1	0.3
Newborn Level 1	1	0.3
Total	296	100

Contributing Factor Areas



Top Five Detailed Primary Contributing Factors in 2019

782 detailed primary factors that contributed to 306 Sentinel Events in 2019, averaging 2.6 factors per event.



Staff – Failure to follow policy

Staff – Clinical Decision Assessment

Patient – Frail - Unsteady

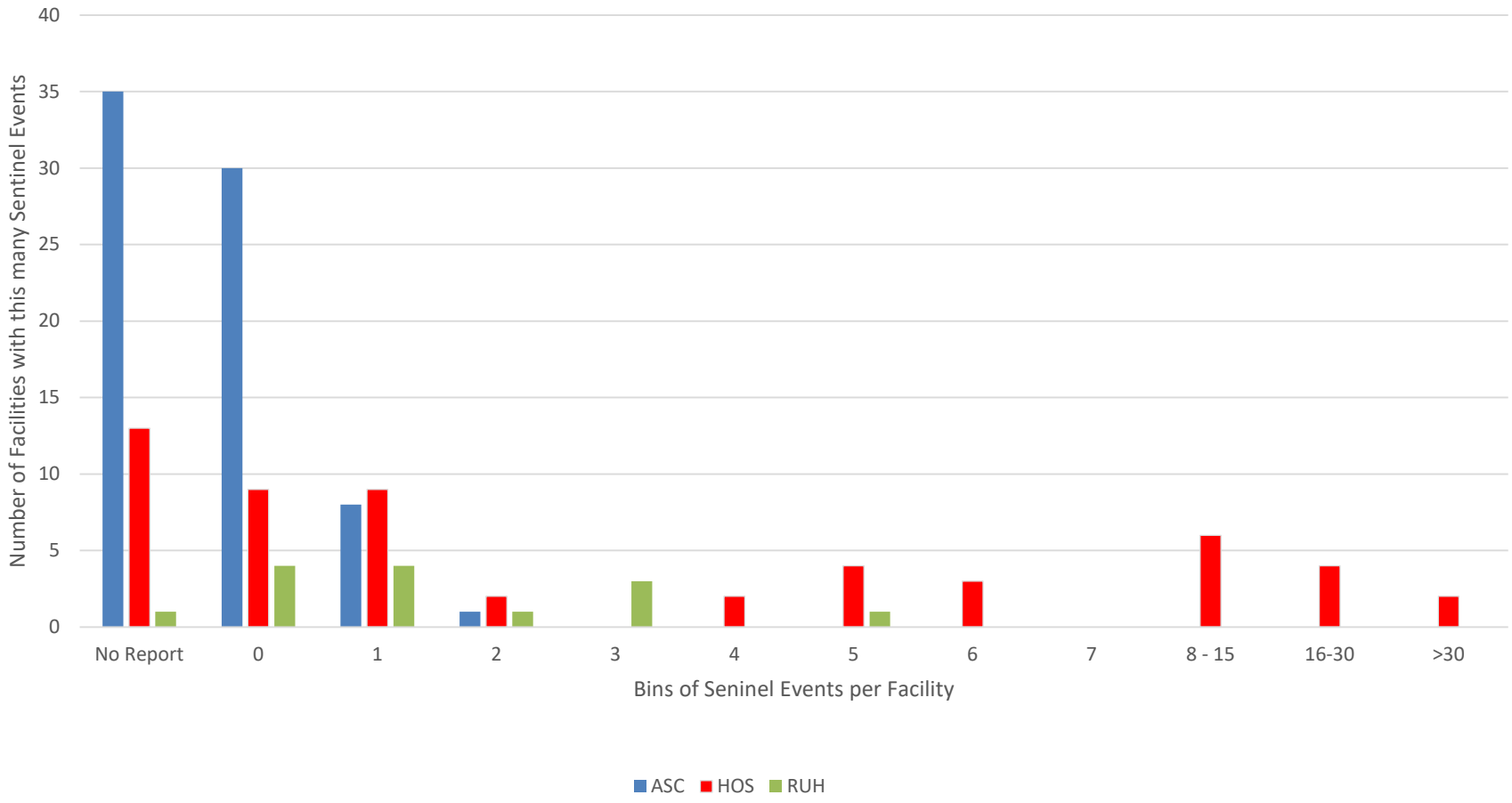
Staff – Clinical Performance Administration

Patient – Impairment Physical

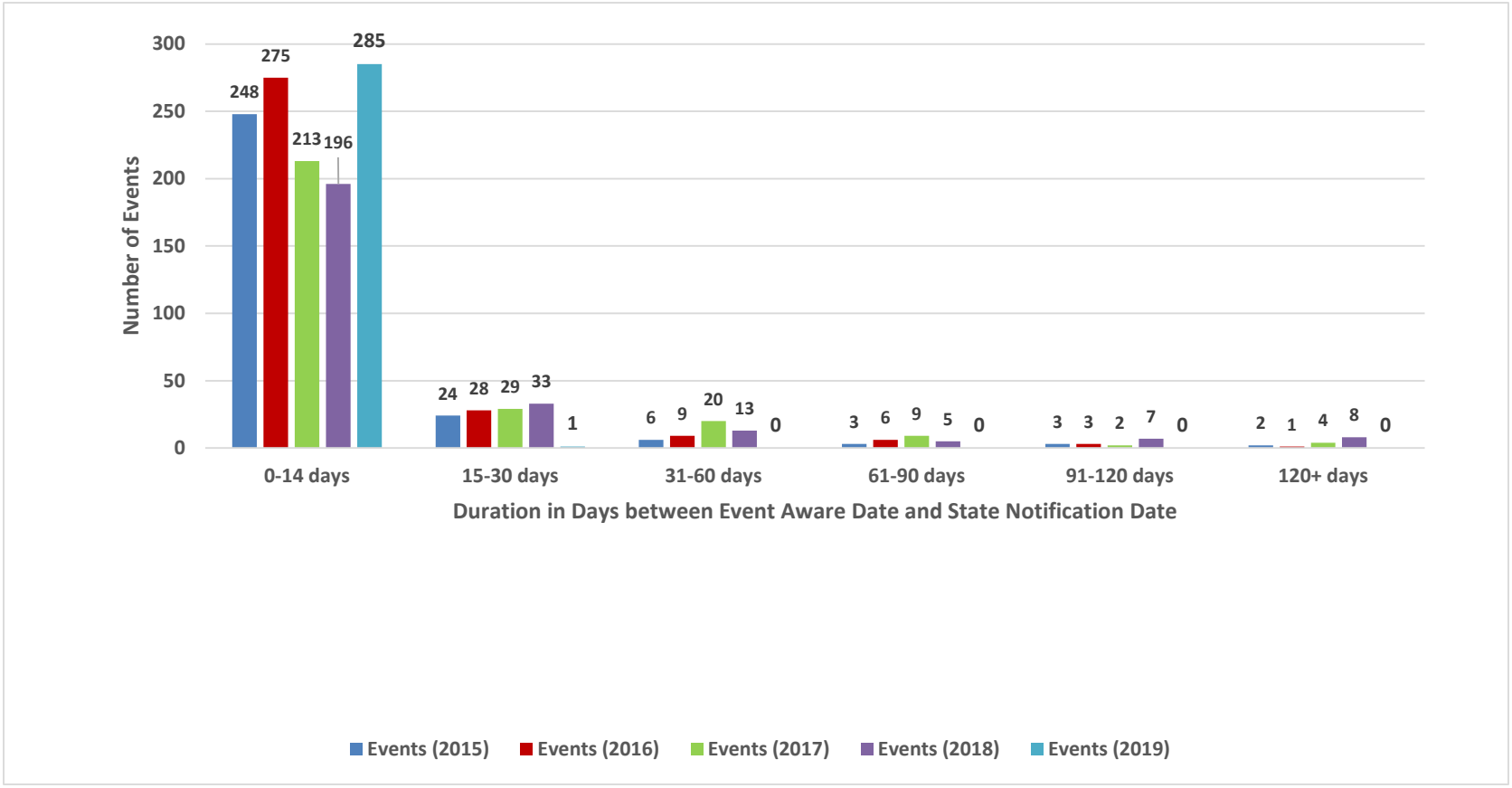
Detailed Primary Factors in 2019 (Up to 4 can be selected)

Factors (up to 4 per event can be selected)	2019 Counts	2019 Percent (%)
Staff Failure Follow Policy or Procedure	97	12.4
Staff Clinical Decision Assessment	92	11.8
Patient Frail Unsteady	74	9.5
Staff Clinical Performance Administration	74	9.5
Patient Physical Impairment	70	9
Patient Non Compliant	54	6.9
Patient Confusion	45	5.8
Communication-Documentation Lack Documentation	33	4.2
Communication-Documentation Handoff Teamwork	30	3.8
Communication-Documentation Verbal Inadequate	30	3.8
Communication-Documentation Lack Communication	26	3.3
Organization Verbal Inadequate	25	3.2
Technology Treatment Delay	14	1.8
Patient Medicated	12	1.5
Organization Culture Principles	10	1.3
Patient Psychosis	9	1.2
Patient Self Harm	8	1
Communication-Documentation Written Inadequate	8	1
Patient Alcohol Drugs	7	0.9
Technology Other	7	0.9
Technology Equipment Failure	6	0.8
Organization Inappropriate or No Policy	5	0.6
Communication-Documentation Written Incorrect	5	0.6
Technology Equipment Unavailable	5	0.6
Organization Staffing Level	4	0.5
Technology Equipment Incorrect	3	0.4
Technology Supplies Incorrect	3	0.4
Patient Allergy Known	2	0.3
Patient Language Barrier	2	0.3
Patient Line Cath Endo Tube Removed	2	0.3
Organization Exceeds	2	0.3
Environmental Emergency Internal	2	0.3
Environmental Noise Level	2	0.3
Technology Supplies Unavailable	2	0.3
Patient Allergy Unknown	1	0.1
Staff Iatrogenic error	1	0.1
Staff Pt ID	1	0.1
Staff Outside Scope of Practice	1	0.1
Environmental Emergency External	1	0.1
Environmental Floor Surface Wet or Slippery	1	0.1
Communication-Documentation Med Record incorrect	1	0.1
Communication-Documentation Transcription error	1	0.1
Communication-Documentation Verbal Incorrect	1	0.1
Technology Incorrect Med Route	1	0.1
Technology Labeling Ambiguous	1	0.1
Technology Test Results Incorrect	1	0.1
Total (detailed primary factors)	782	100

Frequencies by Facility Type in 2019

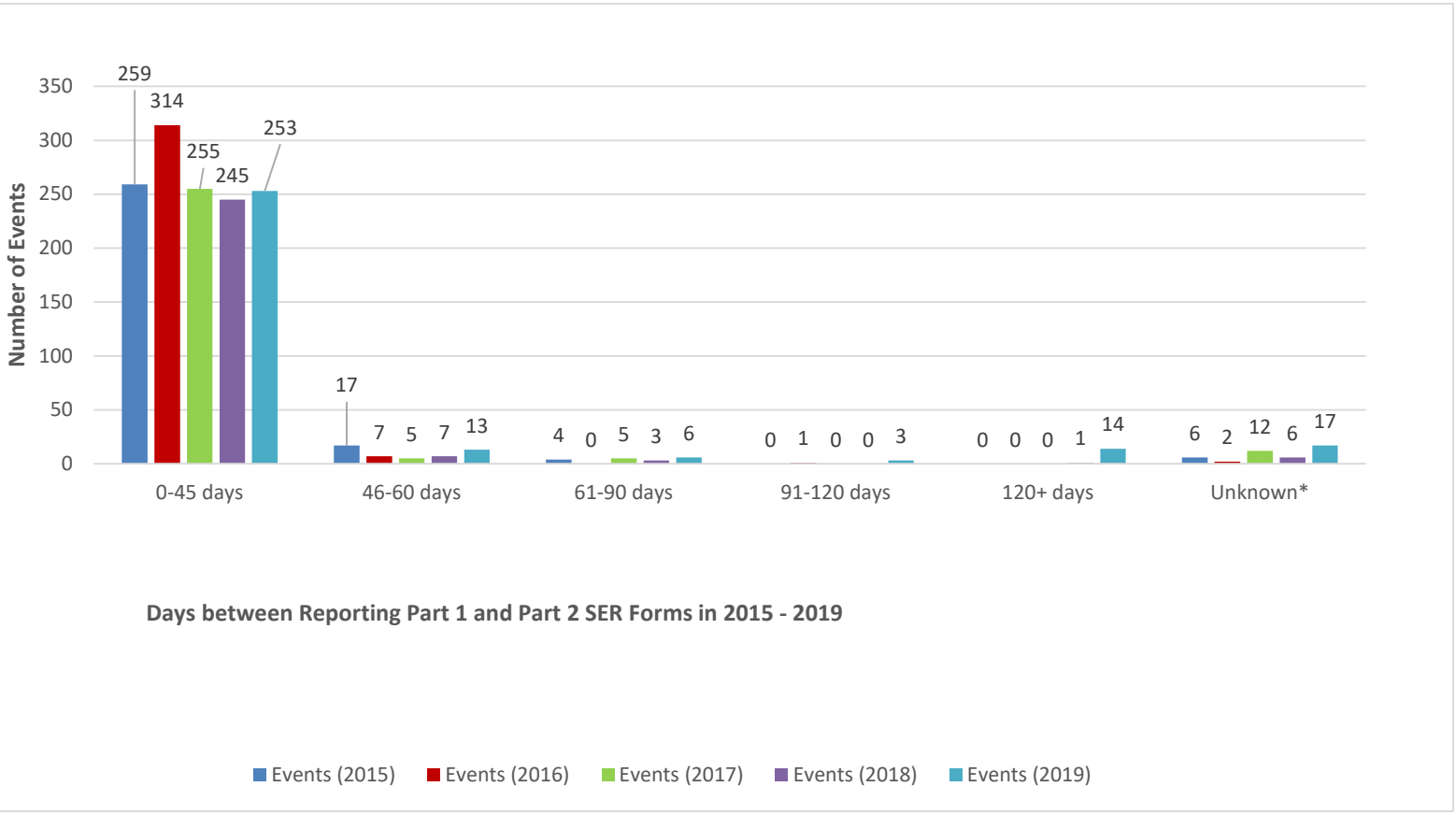


Duration in Days between Event Aware Date and Facility State Notification Date*



* This data is from the event reporting Form 1 and does not include 22 records for bad data and 23 records for fields left blank.

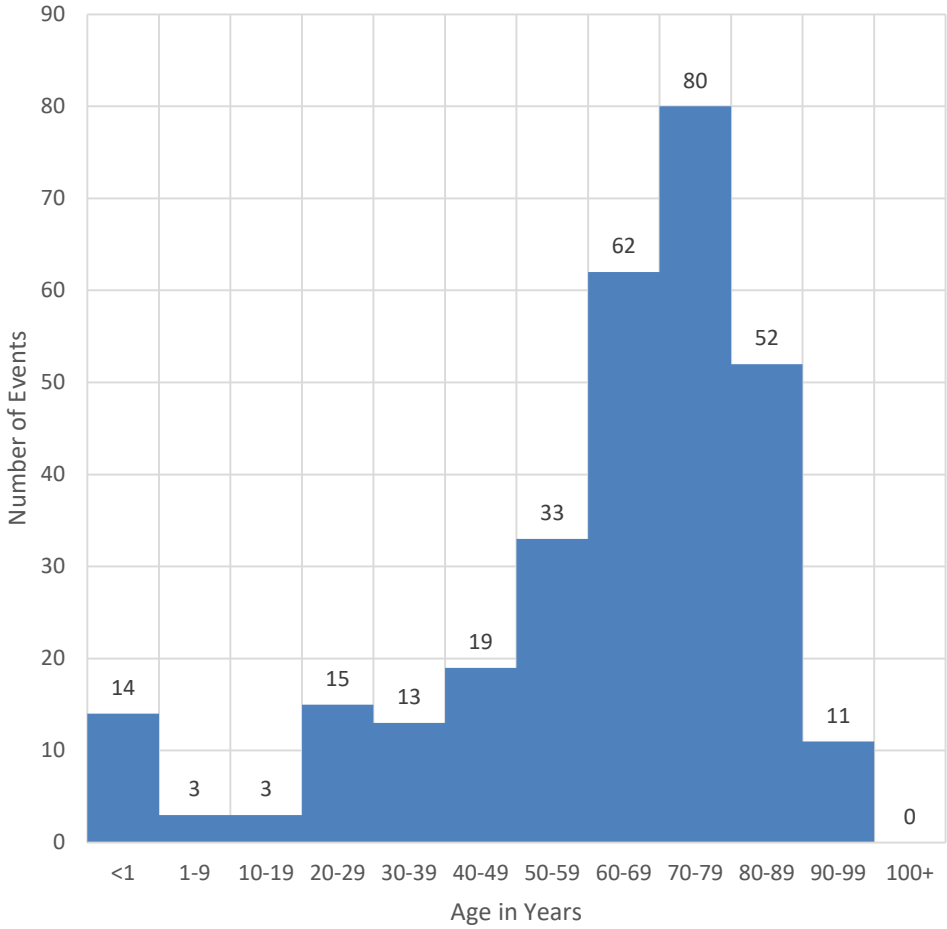
Days Between Event Notification and Analysis Report Completion*



* This data is from event Form 1 Report to event Form 2 Report.

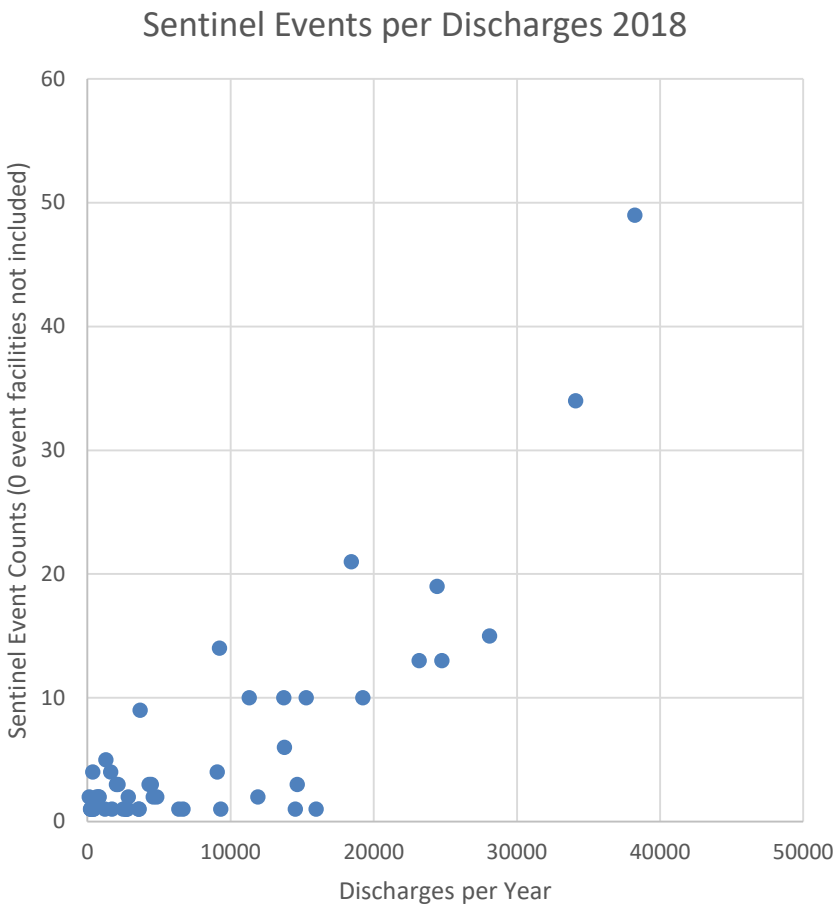
Sentinel Events by Age in 2019

Patient's Age	Count	Percent
<1 year old	14	4.6%
1-9 years old	3	1.0%
10-19 years old	3	1.0%
20-29 years old	15	4.9%
30-39 years old	13	4.3%
40-49 years old	19	6.2%
50-59 years old	33	10.8%
60-69 years old	62	20.3%
70-79 years old	80	26.2%
80-89 years old	52	17.0%
90-99 years old	11	3.6%
100+ years old	0	0.0%
Total (excludes missing DOB)	305	100.00 %



Sentinel Events versus Patient Discharges

- 2019 metric suspended due to data access limitations.
- Overall 0.000645 events per discharge (All facilities).
- For facilities with at least one event,
  - Maximum 0.017 events per discharge
  - Average 0.00074 events per discharge
  - Minimum 0.0000688 events per discharge



Patient Safety Committees 2019

Facilities Having 25 or More Employees and Contractors (2019)			Facilities Having Fewer Than 25 Employees and Contractors (2019)		
Monthly Meetings	Total Facilities	Percentage	Quarterly Meetings	Total Facilities	Percentage
Yes	44	84.62%	Yes	15	100.00%
No	8	15.38%	No	0	0.00%
Did Not Report	0	0.00%	Did Not Report	0	0.00%
Total	52	100.00%	Total	15	100.00%

Facilities Having 25 or More Employees and Contractors (2019)			Facilities Having Fewer Than 25 Employees and Contractors (2019)		
Mandatory Staff	Total Facilities	Percentage	Mandatory Staff	Total Facilities	Percentage
Yes	37	71.15%	Yes	9	60.00%
No	15	28.85%	No	6	40.00%
Did Not Report	0	0.00%	Did Not Report	0	0.00%
Total*	52	100.00%	Total	15	100.00%

REDCap
(Research Electronic Data Capture Application)

- Web based data input in fourth year.
- Mostly Positive Implementation.
- Wide range of Reporter skills and experience.
- Application Best-Practice Provided 1-to-1.
- Continue improving the Sentinel Event FAQ.
- Retooled and standardized for SB457 implementation.

Plans and Goals

- Provide technical assistance and develop improvements to the REDCap Database Reporting System.
- Video version of the Frequently Asked Questions.
- Mini bulletins around most-common factors.
- Study ways to better engage facilities around patient safety and sentinel events.

Conclusion

- The majority of the facilities appear to have followed the procedures and requirements to submit the specific-event and annual summary reports.
- Most had internal patient safety plans.
- Nevada is closer to the forefront on implementing adverse event tracking and improvement of patient safety compared to nearby states.

Reference

- **RESOURCES**
- The Sentinel Events Registry main page is located at: http://dpbh.nv.gov/Programs/SER/Sentinel_Events_Registry_(SER)-Home/
- Sentinel Event reporting guidance and manuals are located at: http://dpbh.nv.gov/Programs/SER/Sentinel_Events_Registry_(SER)-Home/
- The Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report, Appendix A explains in detail each of the Sentinel Event categories used in this report, is located at: http://dpbh.nv.gov/Programs/SER/Sentinel_Events_Registry_(SER)-Home/

Thank you!
From the Team

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Recommended citation:

Nevada State Legislature. *Assembly Bill 28*. 2013 77th Regular Session. Available at: www.leg.state.nv.us/Session/77th2013/Bills/AB/AB28_EN.pdf

Nevada State Legislature. *Assembly Bill 59*. 2005 73rd Regular Session. Available at: http://www.leg.state.nv.us/Session/73rd2005/Reports/history.cfm?ID=1424

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This presentation was produced by the Office of Analytics and the Office of Public Health Investigations and Epidemiology of the Nevada Division of Public and Behavioral Health through budget accounts 3216 and 3219.