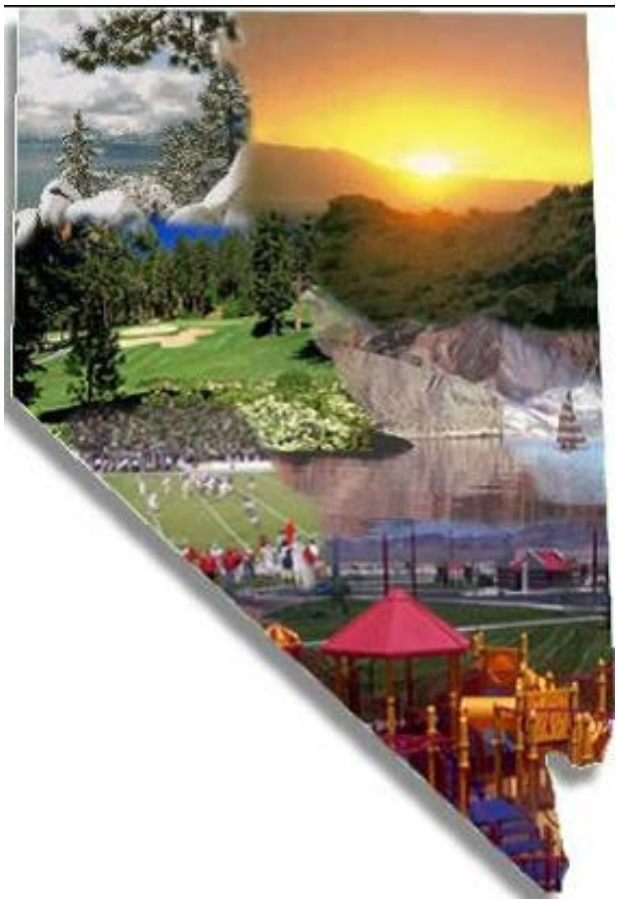

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2015 Annual Sentinel Event Summary Report

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Sentinel Event Report Organization and Contents

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Section I: Executive Summary

Acknowledgments

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The Office of Public Health Informatics and Epidemiology acknowledges all the agencies and healthcare facilities for their ongoing contribution to the Sentinel Event program; the patients and their families who have experienced adverse outcomes and the consequences of clinical errors, and the peer review panels for their advice and recommendations to this report. This report would not be possible without your support, cooperation, and dedication to improve the safety of patient in Nevada.

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Background and Purpose

During the 2009 session, the Nevada Legislature passed law requiring DPBH to compile the Annual Sentinel Event report summaries and submit the compilation to the State Board of Health each year by June 1. The purpose of this report is to share the outcomes, investigations, and root causes of those events. It is intended for use by legislators, healthcare facilities, patients and their families, and the public; it contains both a summary and individual reports submitted by facilities to the Sentinel Event Registry (SER). This is the seventh annual summary report compiled pursuant to Nevada Revised Statutes (NRS) 439.843.

This report will provide a summary of Sentinel Events to all healthcare consumers, healthcare providers, and healthcare organizations and regulators in Nevada from various perspectives and areas. This report aims to help readers not only see the improvement and trends from year to year, but also help identify areas for improvement.

The data in this report reflects a transparency in addressing patient safety issues in Nevada. A facility's size, type, volume of services, complexity of procedures, and staff's understanding of the definition of the Sentinel Event will influence the number of the events reported. It is expected that through the report, healthcare consumers can manage their healthcare decisions better, healthcare providers can learn from these events to prevent them from happening again and develop and implement preventive strategies, and healthcare organizations and regulators will have the appropriate and adequate information to assess accountability of healthcare facilities in Nevada.

Sentinel Event Defined

A sentinel event means an event included in Appendix A of "Serious Reportable Events in Healthcare--2011 Update: A Consensus Report," published by the National Quality Forum. If the publication described above is revised, the term "sentinel events" means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision (NRS 439.830). Use the link below for further details on Appendix A of "Serious Reportable Events in Healthcare."
http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/SER/dta/Publications/CR_serious_reportable_events_2011.pdf.

The Sentinel Events Registry is a database used to collect, analyze, and evaluate such adverse events. The intent is that the reporting of these Sentinel Events will reveal systemic issues across facilities so they may be addressed through quality improvement and educational activities at a systems level.

NRS 439.835 requires that medical facilities report Sentinel Events to DPBH. As specified in NRS 439.805, the medical facility types required to report Sentinel Events are as follows:

- hospitals
- obstetric centers
- surgical centers for ambulatory patients

- independent centers for emergency medical care

Methodology

Pursuant to NRS 439.865, NRS 439.840(2), NRS 439.845(2)b, NRS 439.855 , and NAC439.900-920, each medical facility is required to report Sentinel Events to the SER when the facility becomes aware that a Sentinel Event has occurred. The Sentinel Event report form includes two parts. The Part 1 form includes facility information, patient information, and event information. The Part 2 form includes the facility information, primary contributing factors to the event, and corrective actions. Sentinel Event information is entered into the Sentinel Event database immediately after the forms are received by the Sentinel Event Registrar. Sentinel Event forms can be found at: http://dpbh.nv.gov/Programs/SER/dta/Forms/Sentinel_Event_Registry_(SER)_-_Forms/.

A Sentinel Event report summary form was sent to each medical facility to complete and return to DPBH by March 1, 2015. The following information is required:

a) The total number and types of Sentinel Events reported by the medical facility;
b) A copy of the patient safety plan established pursuant to NRS 439.865; and
c) A summary of the membership and activities of the patient safety committee established pursuant to NRS 439.875.

DPBH sent the summary report form to 127 mandatory Sentinel Event reporting medical facilities. These medical facilities included 62 hospitals, 64 ambulatory surgical centers, and 1 independent center for emergency medical care. Although obstetric centers are also required to report Sentinel Events, there are none currently licensed in Nevada. We received 125 summary reports and two facilities were closed.

Section II: Sentinel Event Summary Report Information

This section provides information regarding the total number of Sentinel Events indicated by the medical facilities as reported on the Sentinel Event report summary forms as well as a breakdown of the event types.

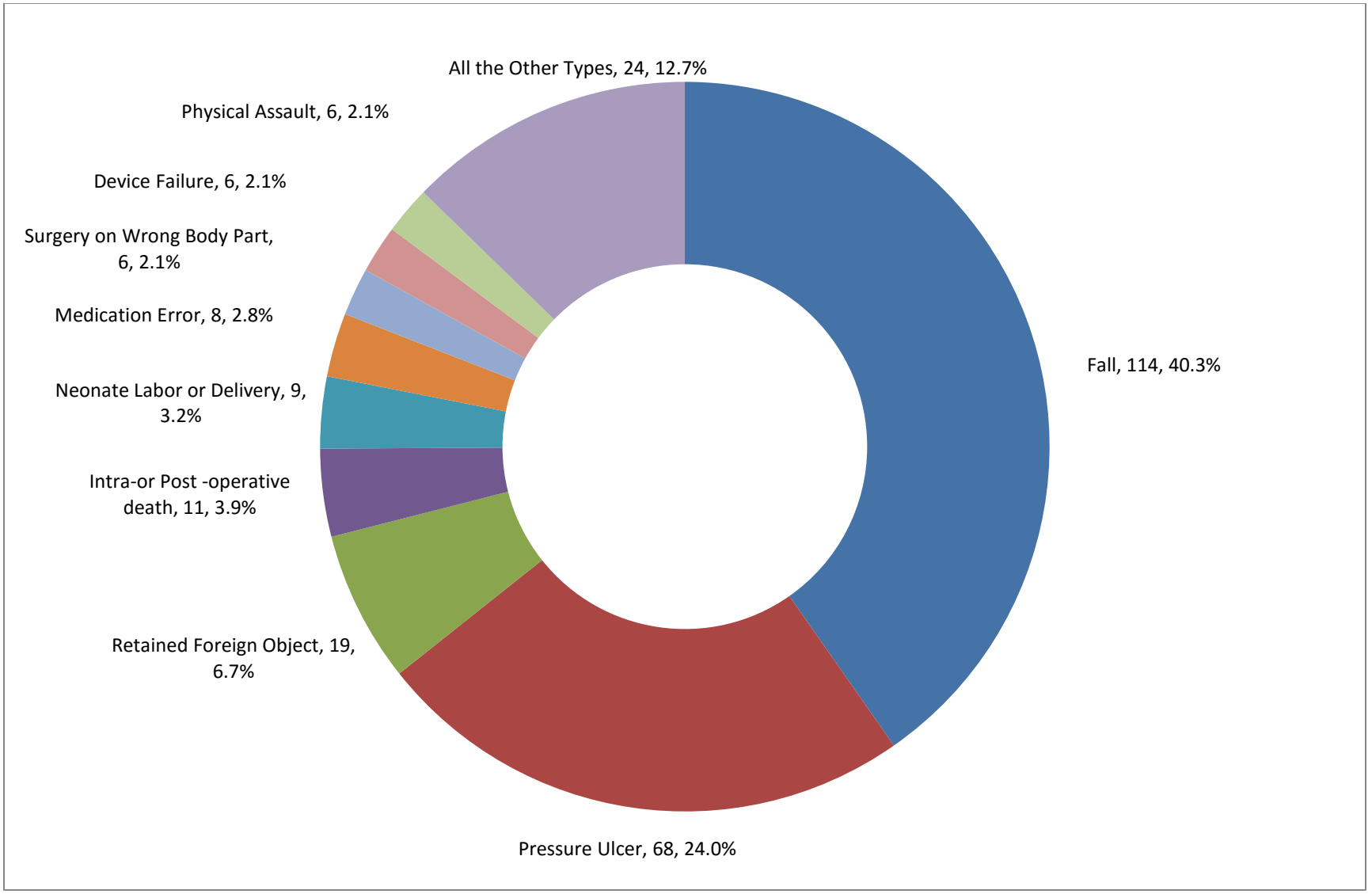
Event Types and Totals

Table 1 lists the types of Sentinel Events reportable with a total for each as indicated on the medical facilities' annual Sentinel Event report summary forms. A percentage of all Sentinel Events reported is provided for each event type. In 2015, the medical facilities indicated that they had reported a total of 283 Sentinel Events.

Table 1: Sentinel Event Type Totals in 2015 (from the summary forms)

No.	Event Type	Totals	Percentage
1	Fall	114	40.3%
2	Pressure Ulcer	68	24.0%
3	Retained Foreign Object	19	6.7%
4	Intra-or Post -operative death	11	3.9%
5	Neonate Labor or Delivery	9	3.2%
6	Medication Error	8	2.8%
7	Surgery on Wrong Body Part	6	2.1%
8	Device Failure	6	2.1%
9	Physical Assault	6	2.1%
10	Elopement	5	1.8%
11	Burn	4	1.4%
12	Wrong Surgical Procedure	3	1.1%
13	Suicide	3	1.1%
14	Maternal Labor or Delivery	3	1.1%
15	Sexual Assault	3	1.1%
16	Failure to Communicate Test Result	2	0.7%
17	Contaminated Drug, Device, or Biologic	1	0.4%
18	Surgery on Wrong Patient	0	0.0%
19	Air Embolism	0	0.0%
20	Discharge to Wrong Person	0	0.0%
21	Transfusion Error	0	0.0%
22	Wrong Sperm or Egg	0	0.0%
23	Lost Specimen	0	0.0%
24	Electric Shock	0	0.0%
25	Wrong or Contaminated Gas	0	0.0%
26	Restraint	0	0.0%
27	Introduction of Metallic Object into MRI area	0	0.0%
28	Abduction	0	0.0%
29	Impersonation of Healthcare Provider	0	0.0%
30	Other	12	4.2%
	Total	**283**	**100.00%**

Figure1: Sentinel Events by Event Type in 2015 (from the summary report form)



Section III: Registry Data Analysis and Comparision between Summary Report and Registry Data

This section will summarize the data that has been received and recorded in the Sentinel Events Registry, and compare the event types to data from the summary forms.

Event Types and Totals

Similar to Table 1, Table 2 lists the types of Sentinel Events reported with totals for the number reported according to both the summary forms and the reports recorded in the Sentinel Events Registry. In 2015, a total of 283 Sentinel Events were reported according to the summary forms versus 286 as recorded in the Sentinel Events Registry. Twelve (12) of these were determined not to be Sentinel Events, bringing the actual total to 274.

Table 2 – Sentinel Event Type Totals from the 2015 Sentinel Event Report Summary Forms and Sentinel Events Registry

Event Type	2014		2015		
	Totals from Summary Report	Totals from Registry Database	Totals from Summary Report	Totals from Registry Database	Difference*
Fall	105	98	114	106	8
Pressure ulcer	66	69	68	67	1
Retained foreign object	18	16	19	20	-1
Intra-or post-operative death	12	13	11	13	-2
Physical assault	27	28	6	12	-6
Surgery on wrong body part	4	3	6	8	-2
Device failure	6	5	6	7	-1
Neonate labor or delivery	1	1	9	7	2
Burn	7	5	4	5	-1
Medication error	8	7	8	6	2
Elopement	6	6	5	4	1
Wrong surgical procedure	2	2	3	4	-1
Suicide	7	7	3	3	0
Sexual assault	5	4	3	3	0
Maternal labor or delivery	2	3	3	3	0

Failure to communicate test result	6	6	2	3	-1
Abduction	1	0	0	1	-1
Contaminated drug, device, or biologic	6	4	1	1	0
Air embolism	0	0	0	1	-1
Impersonation of Healthcare Provider	2	1	0	0	0
Restraint	2	2	0	0	0
Transfusion Error	2	0	0	0	0
Wrong or Contaminated Gas	2	2	0	0	0
Discharge to Wrong Person	1	1	0	0	0
Lost Specimen	1	1	0	0	0
Surgery on wrong Patient	1	2	0	0	0
Procedure Complications	0	1	0	0	0
Other**	0	0	12	0	-12
Total	**300**	**287**	**283**	**274**	**9**

*Difference = Number of events from the summary report – Number of events from the registry database. A positive (+) number indicates the event in the summary report is more than the number in the Registry database. A negative (-) number indicates that the number in the summary report is less than the number in the registry database.

**Other: 12 Sentinel Events categorized as other in the summary form include resident to resident altercations (4), misuse of equipment (1), self-harm (1), procedural complication (1), loss of vision-not facility, staff or surgeon related (1), death after discharge (1), septic shock r/t influenza A. transported to higher level care (1), patient death 24-48 hours post discharge/dos (1), delay in treatment or care (1).

Total Sentinel Events Summary Data vs. Registry Data (2014-2015)

From Table 3, readers will notice that the total number of Sentinel Events from the summary forms and the registry reports all decreased significantly from 2014 to 2015. The decrease rate is 4.53% and 5.67% from the registry reports and the summary forms respectively. The data in 2011-2013 were not listed in this table since the definition of Sentinel Events has been changed since Oct. 1, 2013.

Table 3: Total Events Summary vs. Registry (2014-2015)

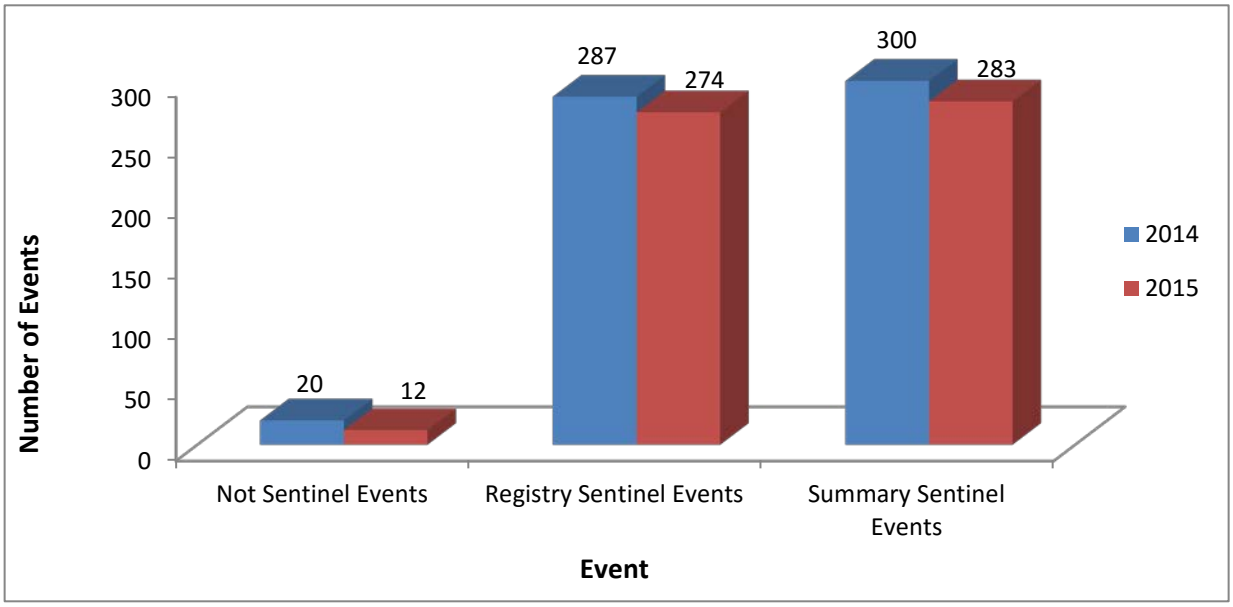
Year	2014	2015
Not Sentinel Events*	20	12
Registry Sentinel Events	287	274
Summary Sentinel Events	300	283

Remark:

*Not Sentinel Event: Upon investigation, it was determined not to be a Sentinel Event after the Part 1 form submission.

In 2015, there were 274 Sentinel Events recorded in the SER database. However, these facilities submitted a total of 283 Sentinel Events in their summary report. Ideally, these two numbers should be the same. The difference details are listed in Table 2.

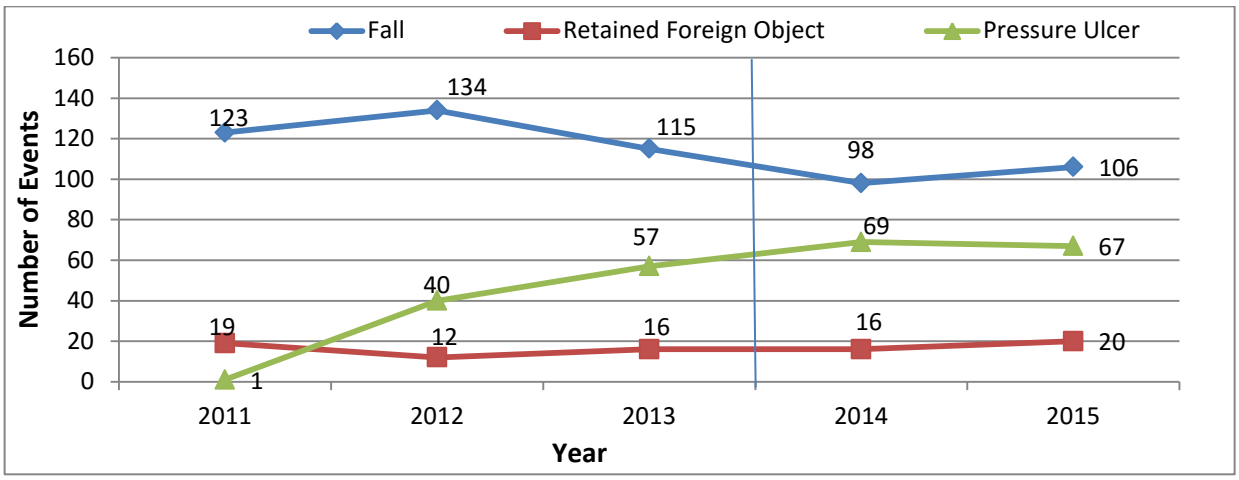
Figure 2: Total Sentinel Events Summary vs. Registry (2014-2015)



Top 3 Types of Sentinel Events in 2015, Compared to Prior 4 Years

Figure 3 shows the top 3 types of Sentinel Events in 2015 compared to prior 4 years. The definition of Sentinel Event has been changed since October 1, 2013. The new definition has been adapted since 2014, and this would affect the data between 2011-2013 time periods and the 2014-2015 time periods. From the graph, readers will notice that “Fall” showed very high number since 2011. It increased from 2014 to 2015 by 8.16%. “Pressure Ulcer” decreased by 2 from 2014 to 2015 and “Retained Foreign Object” increased from 2014 to 2015 by 25%.

Figure 3: Top 3 Types of Sentinel Events in 2015, Compared to Prior 4 Years



Primary Contributing Factors in 2015

In 2015, there were 631 primary factors that contributed to Sentinel Events, which include patient-related, staff-related, communication/documentation, organization, technical, environment, and other primary contributing factors. Table 4 and Figure 4 show the top three primary contributing factors as:

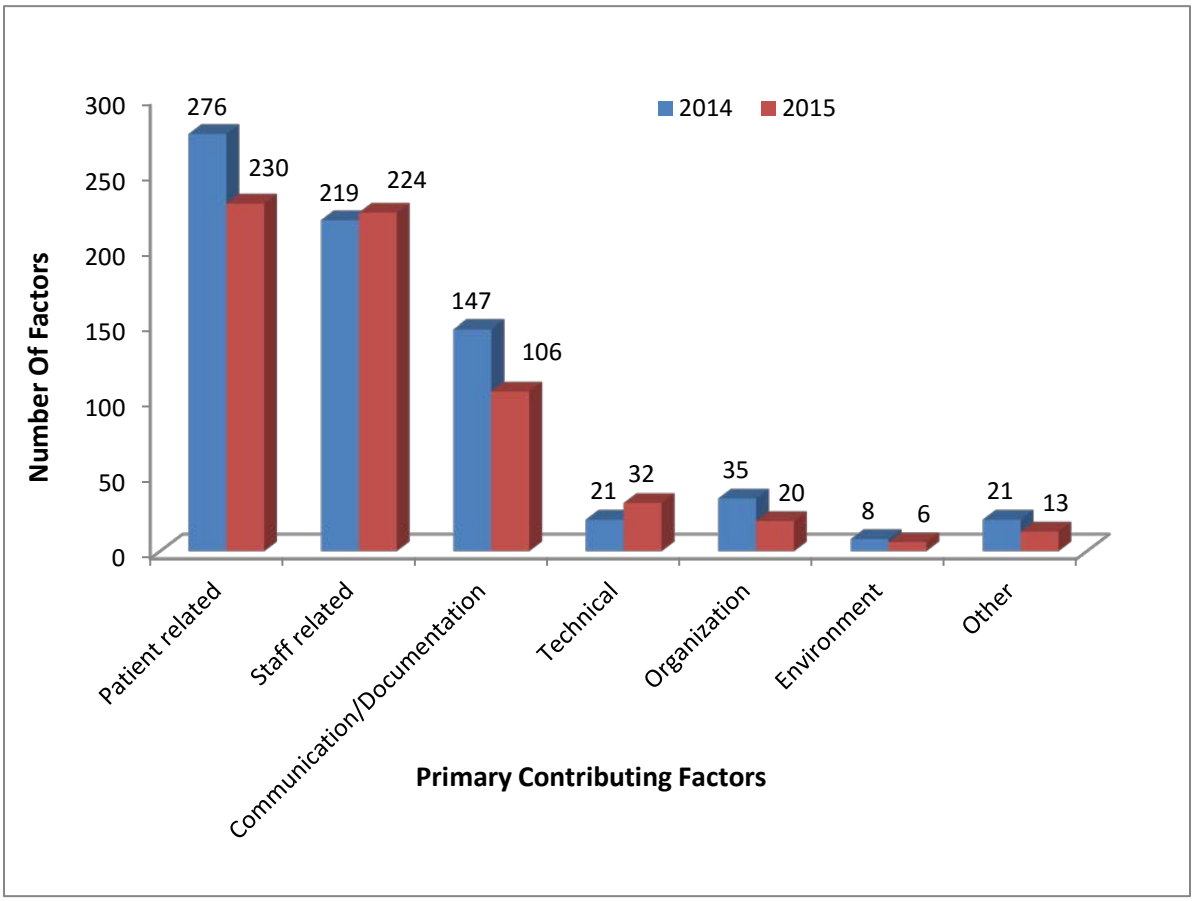
- Patient related: 230 (36.45%)
- Staff related: 224 (35.50%)
- Communication/documentation related: 106 (16.80%).

These three factors constitute 88.75% of the total primary contributing factors in 2015. Comparing with 2014, patient related, communication/documentation, environment, and organization related factors have decreased. However, staff related and technical related factors have increased at rates of 2.28% and 52.38% respectively.

Table 4: Number of Primary Contributing Factors in 2015 Compared to 2014

Primary Factors	2014	2015	Percent (2015)
Patient related	276	230	36.45%
Staff related	219	224	35.50%
Communication/Documentation	147	106	16.80%
Technical	21	32	5.07%
Organization	35	20	3.17%
Environment	8	6	0.95%
Other	21	13	2.06%
Total	**727**	**631**	**100.0%**

Figure 4: Primary Contributing Factors in 2014 and 2015



Detailed Primary Contributing Factors in 2015

The detailed primary contributing factors in 2015 are displayed in Table 5. From the table, readers will notice that the factor Clinical Decision/Assessment contributed to 103 events (16.3% of the total events); Failure to Follow Policy/or Procedure contributed to 77 events (12.2% of the total events); and non-compliant contributed to 63 events (10.0%). Compared with 2014, the contributing factors including clinical decision/assessment, non-compliant, equipment failures have increased, and the increasing rates are 17.05%, 28.57%, and 100% respectively. The contributing factors such as frail/unsteady, physical impairment, hand off/team work/cross coverage, lack of communication, and medicated have decreased.

Table 5: Detailed Primary Contributing Factors in 2015

Primary Contributing Factors	Count	Percent
Clinical decision/assessment	103	16.3%
Failure to follow policy and/or procedure	77	12.2%
Non-compliant	63	10.0%
Frail/unsteady	53	8.4%
Physical impairment	46	7.3%
Clinical performance/administration	39	6.2%
Confusion	35	5.5%
Lack of/inadequate documentation	27	4.3%
Hand off/teamwork/cross coverage	26	4.1%
Verbal communication inadequate	24	3.8%
Lack of communication	20	3.2%
Medicated	12	1.9%
Equipment failures	12	1.9%
Inappropriate/no policy/process	10	1.6%
All other factors	84	13.3%
Total	**631**	**100.0%**

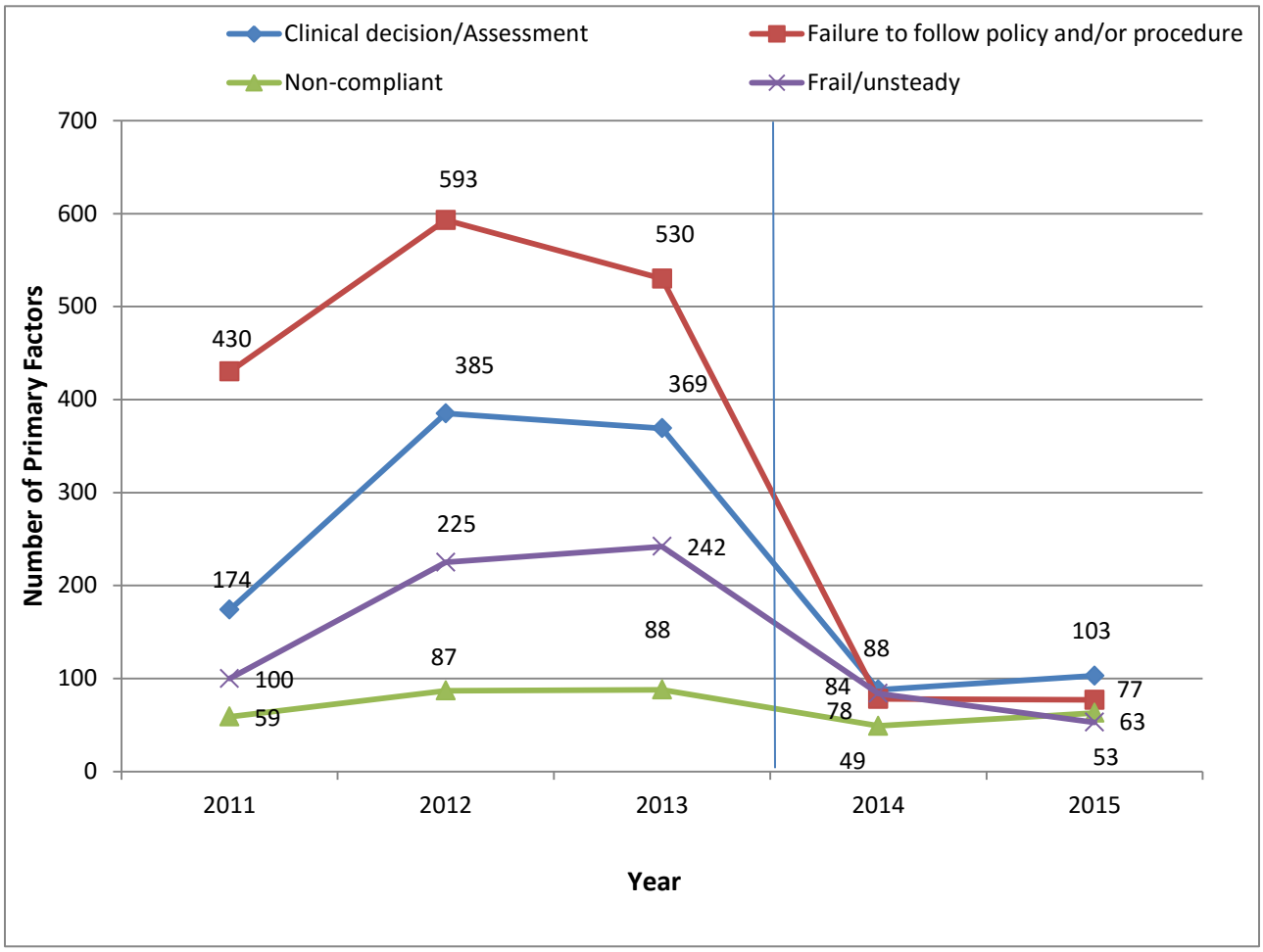
Top 4 Contributing Factors in 2015, Compared to Prior 4 Years

Table 6 and Figure 5 below show the top 4 contributing factors in 2015 compared to the prior 4 years. The data indicate that these contributing factors dramatically decreased from 2013 to 2014. However, the clinical decision/assessment and non-compliant factors increased from 2014 to 2015, from 17.05% to 28.57%. Failure to follow policy and/or procedure is maintained from 2014 to 2015. However, frail/unsteady showed a significant decrease of 36.9%.

Table 6: The Top 4 Primary Contributing Factors in 2015, Compared to Prior 4 Years

Year	Clinical decision/assessment	Failure to follow policy and/or procedure	Non-compliant	Frail/unsteady
2011	174	430	59	100
2012	385	593	87	225
2013	369	530	88	242
2014	88	78	49	84
2015	103	77	63	53

Figure 5: The Top 4 Primary Contributing Factors in 2015, Compared to Prior 4 Years



Note: The definition of Sentinel Event has been changed since October 1, 2013. The new definition has been used since 2014, and this would affect the numbers from 2013 to 2014.

Average Sentinel Events by Facility Type in 2015

Figure 6 and Table 7 illustrate the average Sentinel Events for each type of facility in 2015. ASC (Surgical Center for Ambulatory Patients) showed a low average with 0.17 events per facility in 2015. HOS (Hospitals, which excludes rural hospitals) had an average of 5.23 events per hospital and the RUH (rural hospitals) indicates an average of 1.71 events per hospital in 2015. Nevada's ICE (Independent Center for Emergency Medical Care) reported no Sentinel Events in 2015.

Figure 6: Average Number of Sentinel Events by Facility Type

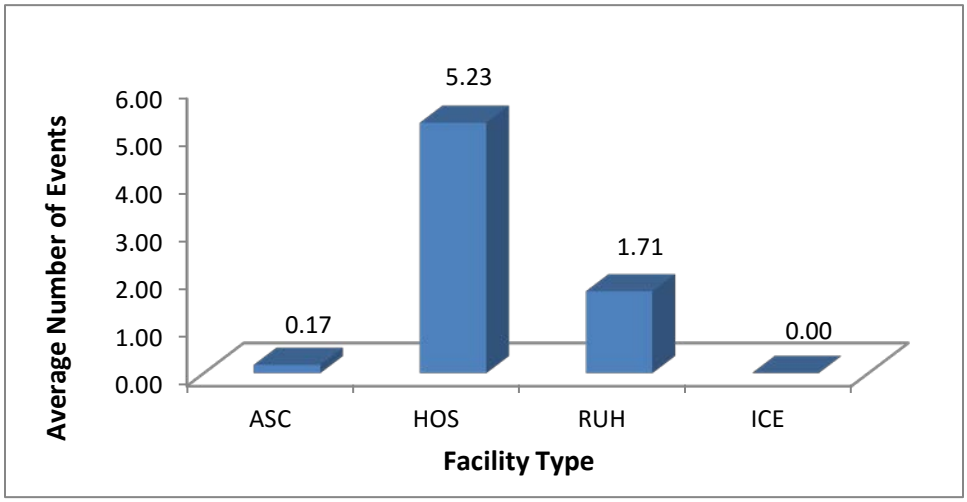


Table 7: Average Sentinel Events by Facility Type

Facility Type	Number of Facilities	Number of Events	Average Events Per Facility
ASC	64	11	0.17
HOS	48	251	5.23
RUH	14	24	1.71
ICE	1	0	0.00
Total	127	286	2.25

Notes: The data is inclusive of all events from SER database.

Sentinel Events by County in 2015

Table 8 shows that Clark County had 212 events and Washoe County had 21 events, representing 74.13% and 7.34% of the total events respectively in 2015. These two counties contributed 81.47 % (233/286) of the statewide Sentinel Events in 2015 since these two counties vast majority of Nevada's populations are in these two counties. Compared with 2014, Washoe County, Carson City, and Humboldt County greatly decreased their numbers of Sentinel Events. However, Lyon and Mineral counties increased their numbers of Sentinel Events. The data is from the SER database and is inclusive of all the events in the database.

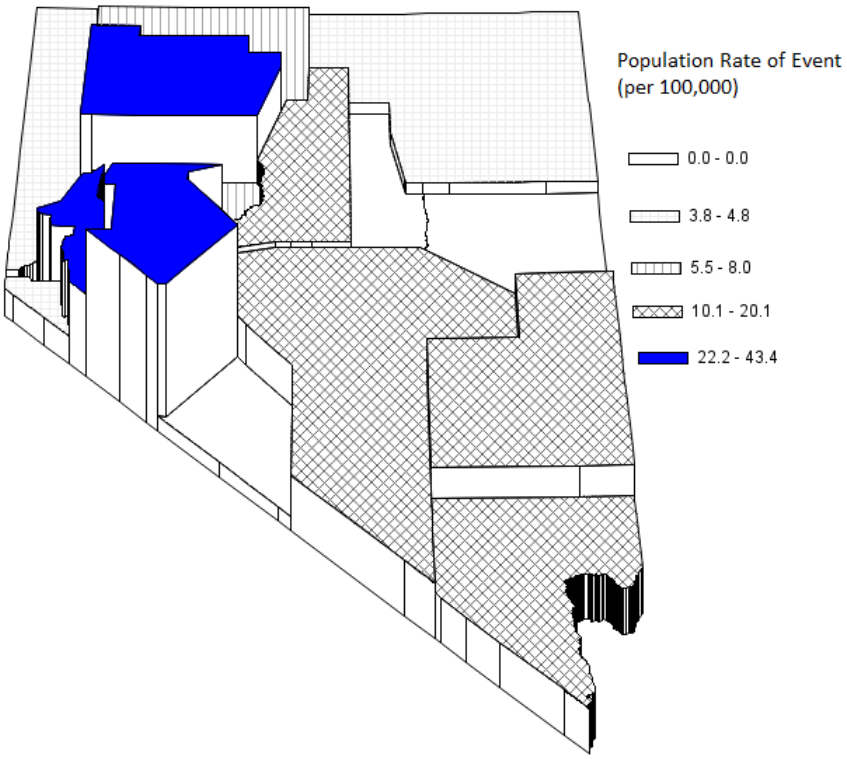
Table 8: Sentinel Events by County in 2014 and 2015 (inclusive of all events from SER database)

County	Number of Events (2014)	Number of Events (2015)	Percent (2015)
Carson City	6	3	1.05%
Churchill	1	2	0.70%
Clark	212	212	74.13%
Douglas	3	2	0.70%
Elko	1	2	0.70%
Humboldt	3	1	0.35%
Lander	1	1	0.35%
Lincoln	2	1	0.35%
Lyon	5	12	4.20%
Mineral	0	2	0.70%
Nye	6	6	2.10%
Pershing	1	2	0.70%
Washoe	45	21	7.34%
missing data	1	0	0.00%
Other*(patients outside Nevada)	20	17	5.94%
Total	**307**	**286**	**100%**

Other*: Patients were from outside Nevada.

Figure 7 illustrates the population rates of Sentinel Events in each county. The population data are from the Nevada state demographer in 2015. The top 3 event rates are: Mineral County (43.4 per 100,000), Pershing County (29.7 per 100,000), and Lyon County (22.2 per 100,000).

Figure 7: Map for Sentinel Events Rate by County in 2015



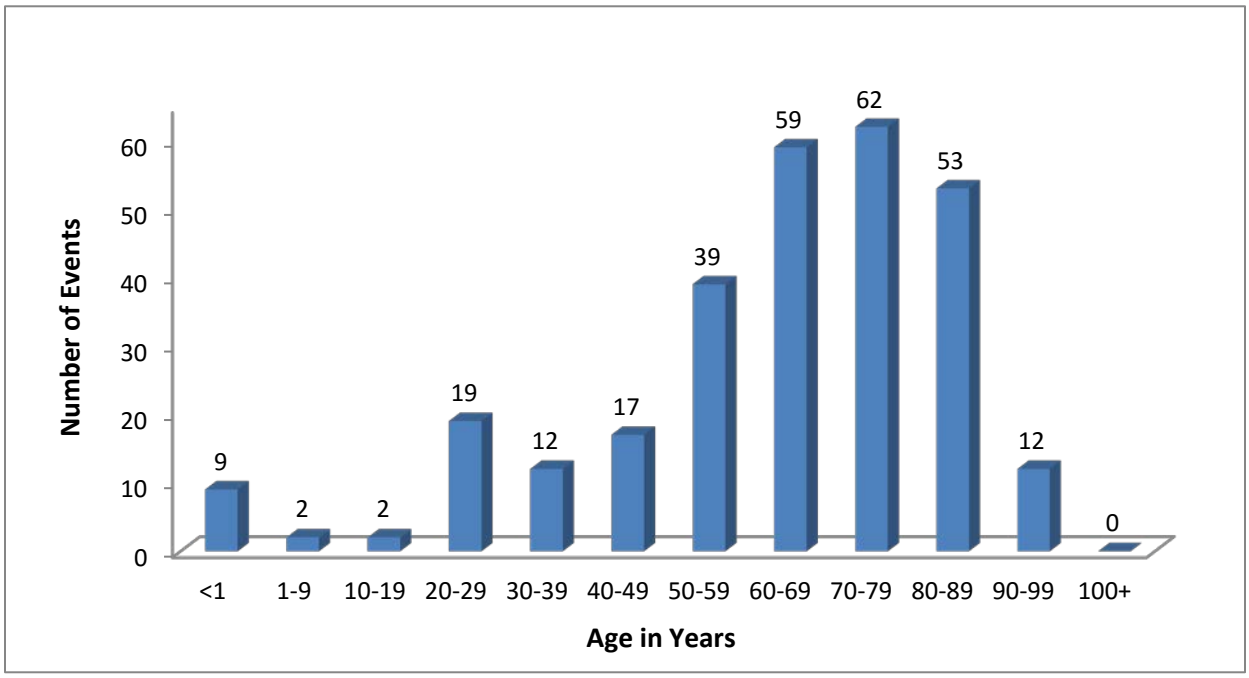
Sentinel Events by Age in 2015

Table 9 and Figure 8 below show that 213 Sentinel Events occurred to patients between age 50 and 89 years, which accounts for 74.5% of the total events.

Table 9: Sentinel Events by Age in 2015 (inclusive of all the events from the SER database)

Patient's Age	Count	Percent
<1 year old	9	3.15%
1-9 years old	2	0.70%
10-19 years old	2	0.70%
20-29 years old	19	6.64%
30-39 years old	12	4.20%
40-49 years old	17	5.94%
50-59 years old	39	13.64%
60-69 years old	59	20.63%
70-79 years old	62	21.68%
80-89 years old	53	18.53%
90-99 years old	12	4.20%
100+ years old	0	0.00%
Total	**286**	**100.00%**

Figure 8: Sentinel Events by Age in 2015 (inclusive of all the events from the SER database)



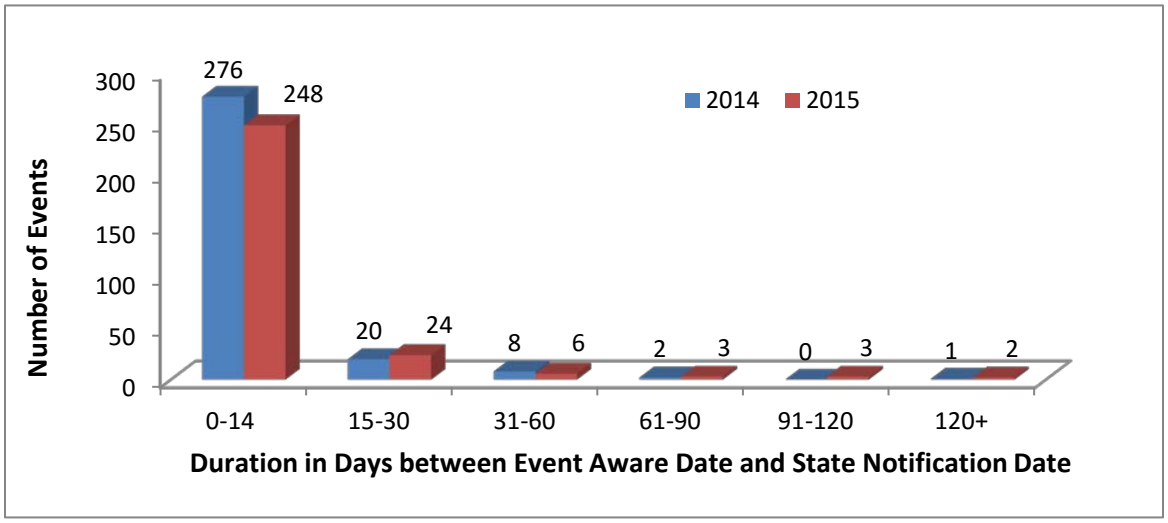
Duration in Days between Event Aware Date and Facility State Notification Date

According to NRS 439.835, facilities must notify the SER within 13 or 14 days depending upon if the patient safety officer or another healthcare worker discovers the event. Table 10 and Figure 9 show most facilities (248, 86.71 %) notified the SER within 14 days after the event. There were 24 events (8.39%) that were reported to the SER between 15 days and 30 days after the event, and 14 events that were reported more than 30 days after the event. The Sentinel Events reported to the state within 14 days has decreased from 89.9% to 86.7% from 2014 to 2015.

Table 9: Duration between Event Aware Date and State Notification Date (inclusive of all the events from the SER database)

Duration	Events (2014)	Events (2015)	Percent (2015)
0-14 days	276	248	86.71%
15-30 days	20	24	8.39%
31-60 days	8	6	2.10%
61-90 days	2	3	1.05%
91-120 days	0	3	1.05%
120+ days	1	2	0.70%
Total	**307**	**286**	**100.00%**

Figure 9: Duration between Event Aware Date and State Notification Date in 2014 and 2015 (inclusive of all the events from the SER database)



Duration in Days between SER Part 1 Form and Part 2 Form

According to NRS 439.835 within 14 days of becoming aware of a reportable event, mandatory reporters must submit to the SER the Part 1 form. Within 45 days of submitting the Part 1 form, the facility is required to submit the Part 2 form, which includes the facility's quality improvement committee describing key elements of the events, the circumstances surrounding their occurrence, the corrective actions that have been taken or proposed to prevent a recurrence, and methods for communicating the event to the patient's family members or significant other. Upon processing the Part 1 report, SER sends an email to remind the medical facilities when the SER Part 2 form will be due.

Table 11 and Figure 10 illustrate that in 2015 more than 90% facilities submitted their Part 2 form within 45 days of submitting the Part 1 form, an increase from 85.67% in 2014. Six (6) events are categorized as "other" since they were not Sentinel Events and were not required to provide Part 2 forms.

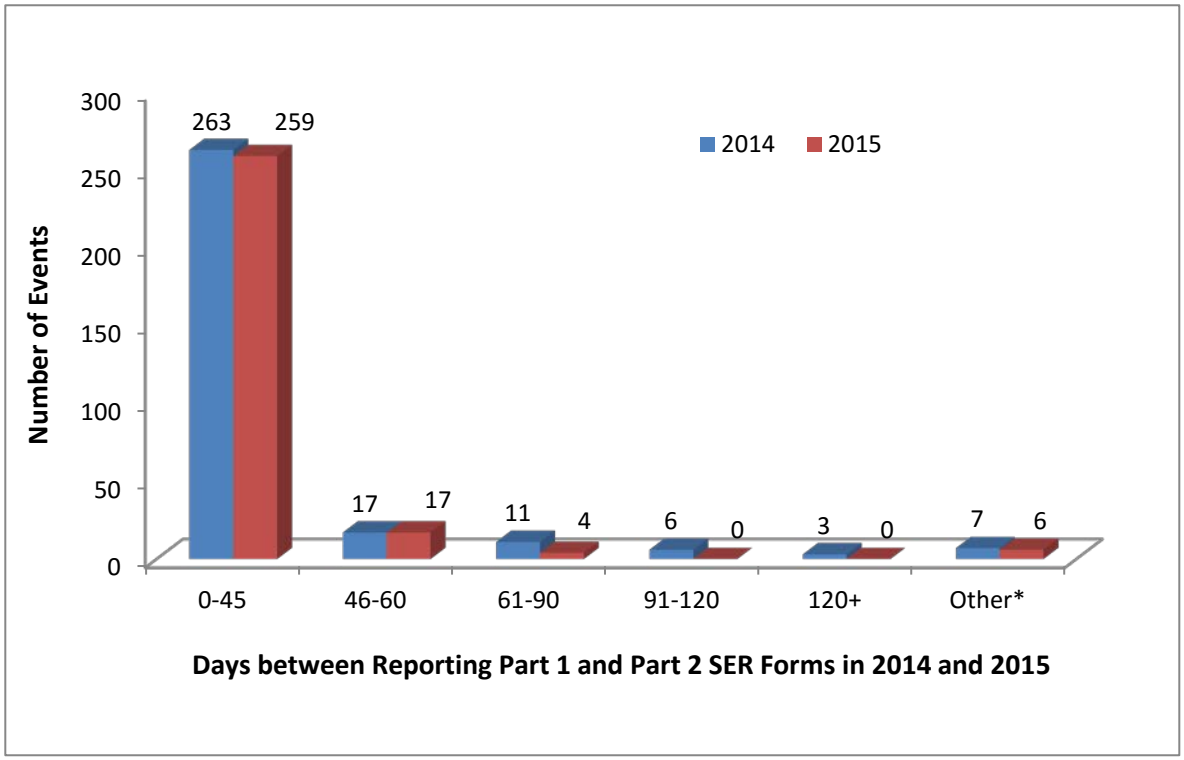
Table 11: Reporting Duration in Days between SER Part 1 Form and SER Part 2 Form (inclusive of all events from SER database)

Days between Part 1 and Part 2 SER Report Submission	Events (2014)	Events (2015)	Percent (2015)
0-45 days	263	259	90.56%
46-60 days	17	17	5.94%
61-90 days	11	4	1.40%

91-120 days	6	0	0.00%
120+ days	3	0	0.00%
Other*	7	6	2.10%
Total Events	**307**	**286**	**100.00%**

Other*: Upon investigation, it was determined not to be a Sentinel Event after the Part 1 form.

Figure 10: Duration in Days between Reporting Part 1 and Part 2 SER Forms in 2014 and 2015



Duration in Days Between Event Aware Dates and the Patient Notification Dates and the Noticification Methods

As shown in table 12, patients affected by approximately 95% events were notified within one day as long as the facilities were aware of the occurrence of the Sentinel Events. Table 13 indicates the predominant notification methods are telling the patient in person (219, 76.6%) or over the telephone (58, 20.3%).

Table12: Duration in Days between Event Aware and the Patient Notification Date.

Duration (days)	Events	Percent
<1	270	94.4%
1-3	2	0.7%
3-5	6	2.1%
5-7	3	1.0%
7+	5	1.7%
Total	286	100.0%

Table 13: Method of Notification to the Patient.

Notification methods	Events	Percent
Told in Person	219	76.6%
Telephone	58	20.3%
Mail	7	2.4%
Hand-Delivered Message	1	0.3%
Missing Data	1	0.3%
Total	286	100.0%

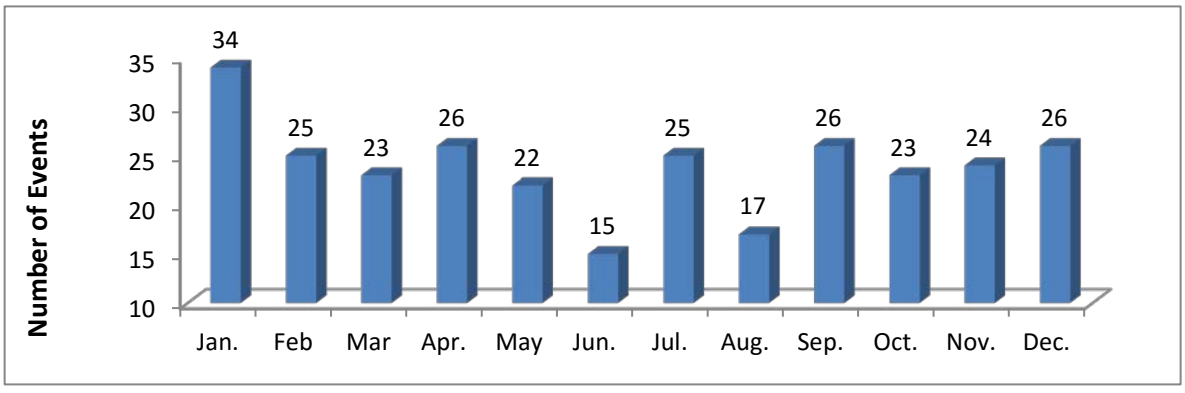
Sentinel Events by Month in 2015

Table 14 and Figure 11 indicate that January was the peak month for Sentinel Events occurrence in 2015, tallying 42.7% higher than the average of 23.8 events per month, and 127% higher than June, which had the lowest occurrence of the Sentinel Events in 2015. June and August were the two lowest months of the Sentinel Events occurrence in 2015. The other months had between 22 and 26 Sentinel Events with an approximate average of 24 per month.

Table 14: Sentinel Events by Month in 2015 (inclusive of all events from SER database)

Month	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Total
# Events	34	25	23	26	22	15	25	17	26	23	24	26	286

Figure 11: Sentinel Events by Month in 2015 (inclusive of all events from SER database)



Department or Locations where Sentinel Events Occurred in 2015

Table 15 indicates that approximately 50% of Sentinel Events occurred at medical/surgical department and intensive/critical care department in 2015.

Table 15: Department or Location Where Sentinel Events Occurred in 2015 (inclusive of all events from SER database)

Department/Location	Count	Percent
Medical/surgical	94	36.7%
Intensive/critical care	33	12.9%
Long-term care	23	9.0%
Psychiatry/behavioral health/Geropsychiatry	19	7.4%
Emergency department	18	7.0%
Inpatient rehabilitation unit	18	7.0%
Inpatient surgery	16	6.3%
Outpatient/ambulatory surgery	15	5.9%
Intermediate care	12	4.7%
Labor/delivery	8	3.1%

Department/Location	Count	Percent
Ancillary/other	5	2.0%
Anesthesia/PACU	4	1.6%
Cardiac catheterization suite	3	1.2%
Imaging	3	1.2%
Neonatal unit (level 3)	3	1.2%
Pediatric intensive/critical care	3	1.2%
Postpartum	3	1.2%
Endoscopy	2	0.8%
Observational/clinical decision unit	2	0.8%
Outpatient/ambulatory care	2	0.8%
Total	286	100.0%

Section IV: Patient Safety Plans

In accordance with NRS 439.865, each medical facility is required to develop an internal patient safety plan to protect the health and safety of patients who are treated at their medical facility. The patient safety plan is to be submitted to the governing board of the medical facility for approval and the facility must notify all healthcare providers who provide treatment to patients in their facility of the plan and its requirements.

All medical facilities submitted some sort of document as a patient safety plan in response to the 2015 Sentinel Event report summary form. As was the case from 2009 to 2014, there was great variety in the documents submitted, ranging from fully comprehensive plans to single-page documents. Patient safety plans are addressed in NRS 439.865.

Patient Safety Committees

In accordance with NRS 439.875, medical facilities must establish a patient safety committee.

The composition of the committee and the frequency with which it is required to meet varies depending on the number of employees at the facility.

A facility with 25 or more employees must have a patient safety committee comprised of:

1) The infection control officer of the medical facility;
2) The patient safety officer of the medical facility, if he or she is not designated as the infection control officer of the medical facility;
3) At least three providers of healthcare who treat patients at the medical facility, including, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
4) One member of the executive or governing body of the medical facility.

Such a committee must meet *at least once each month*.

In accordance with NAC 439.920**,** a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

1) The patient safety officer of the medical facility;
2) At least two providers of healthcare who treat patients at the medical facility, including, without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
3) The chief executive officer (CEO) or chief financial officer (CFO) of the medical facility.

Such a committee must meet *at least once every calendar quarter*.

In either case, a facility's patient safety committee must, at least once each calendar quarter, report to the executive or governing body of the medical facility regarding:

1) The number of Sentinel Events that occurred at the medical facility during the preceding calendar quarter; and
2) Any recommendations to reduce the number and severity of Sentinel Events that occurred at the medical facility.

According to the summary reports provided by the medical facilities, 77 facilities indicated they had 25 or more employees, and 48 indicated that they had fewer than 25. Overall, the patient safety committees at 117 of the 125 facilities (93.6%) met as frequently as required. Among the facilities that had 25 or more employees, 70 (90.91%) of the patient safety committees met on a monthly basis. Among the facilities that had fewer than 25 employees, 47 (97.92%) of the patient safety committees met on a quarterly basis. Table 16 shows these figures.

Table 16: Compliance with Mandated Meeting Periodicity among Facilities

Facilities Having 25 or More Employees			Facilities Having Fewer Than 25 Employees and Contractors		
Monthly Meeting	**Total Facilities**	**Percentage**	**Quarterly Meeting**	**Total Facilities**	**Percentage**
Yes	70	90.91%	Yes	47	97.92%
No	7	9.09%	No	1	2.08%
Total	**77**	**100.00%**	**Total**	**48**	**100.00%**

All patient safety committees had the appropriate staff in attendance at the patient safety committee meetings. Table 17 shows this in greater detail. Table 16 and Table 17 show that some facilities who having 25 or more employee did not have monthly meeting. However, when they have meetings, they had mandatory staff attend the meetings.

Table 17: Compliance with Mandated Staff Attendance among Facilities

Facilities Having 25 or More Employees			Facilities Having Fewer Than 25 Employees and Contractors		
Mandatory Staff	**Total Facilities**	**Percentage**	**Mandatory Staff**	**Total Facilities**	**Percentage**
Yes	76	98.70%	Yes	47	97.92%
No	1	1.30%	No	1	2.08%
Total	**77**	**100.00%**	**Total**	**48**	**100.00%**

Section V: Plans, Conclusion, and Resources

Plans and Goals for the Upcoming Year

Nevada's Sentinel Event Registry program is in the process of developing a web-based Sentinel Event reporting project by using REDCap (Research Electronic Data Capture) database to replace the current submission of Sentinel Events via fax.

The Sentinel Event Registry program is developing a sentinel event toolkit that will clarify the reporting procedures to ensure reliable and accurate reporting of Sentinel Events.

In 2016, the SER will continue to enhance the Sentinel Event registry program in the following areas:

- Provide the technical assistance related to the REDCap reporting systems, the new Sentinel Event toolkits, and consultations as requested.
- Implement the Sentinel Events reporting statutes.
- Continue to look for the best practices in Sentinel Event reporting systems.

- Continue to maintain ongoing communication with the related facilities and stakeholders regarding reporting requirements, corrective actions, and lessons learned to prevent the events from being repeated, and reduce or eliminate preventable incidents, in order to help facilitate the improvement in the quality of healthcare for citizens in Nevada.
- Assist the sentinel event related educational activities to help facilities increase their skills in root cause analysis and process improvement.

Conclusion

Sentinel Event reporting focuses on identifying and eliminating serious, preventable incidents. Mandatory reporting, including reporting of Sentinel Events, lessons learned, corrective actions, and the patient safety committee activities are key factors for the state of Nevada to hold facilities accountable for disclosing that an event has occurred and that appropriate action has been taken to prevent similar events from occurring in the future. The system was designed for continuous improvement to the quality of services provided by the facilities by learning from prior Sentinel Events to establish better preventive practices.

Improving patient safety is the responsibility of all stakeholders in the healthcare system, and includes patients, providers, health professionals, organizations, and government. From the data analysis, readers can see that the total number of Sentinel Events has decreased in 2015 compared to 2014. Most of the facilities followed the procedures and requirements to submit the reports and had internal patient safety plans. However, there were some areas for improvement in the future.

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 2012 Sentinel Event reporting guidance, which 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/

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/

Citations

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

National Quality Forum. *Serious Reportable Events In Healthcare-2011 Update: A Consensus Report*. Washington, DC: NQF; 2011. Available at: www.qualityforum.org/Publications/2011/12/Serious_Reportable_Events_in_Healthcare_2011.aspx

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