2012 ANNUAL
SENTINEL EVENT SUMMARY REPORT

Department of Health and Human Services
Nevada State Health Division
Office of Public Health Informatics and Epidemiology

Brian Sandoval, Governor
State of Nevada

Michael J Willden, Director
Department of Health and Human Services

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Richard Whitley, MS, Administrator
Health Division

Tracey D Green, MD, State Health Officer
Health Division

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PURPOSE

Legislation passed during the 2009 Legislative Session requires the Nevada State Health Division (NSHD) to compile the annual sentinel event report summaries and submit the compilation to the State Board of Health each year by June 1. This is the fourth annual summary report to be compiled pursuant to Nevada Revised Statutes (NRS) 439.843.

SENTINEL EVENT DEFINED

NRS 439.830 defines a sentinel event as:

> "… an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function."

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 that they may be addressed more widely through quality improvement and educational activities.

NRS 439.835 requires that medical facilities report sentinel events to NSHD. 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

As a result of Assembly Bill 28 which becomes effective October 1, 2013, the definition of a "sentinel event" was amended to mean "an event included in Appendix A of 'Serious Reportable Events in Healthcare—2011 Update: A Consensus Report,' published by the National Quality Forum". The report published by the National Quality Form has gone through three iterations, 2002, 2006 and 2011.

METHODOLOGY

On February 19, 2013, each medical facility was sent a sentinel event report summary form to be completed and returned to NSHD by March 1, 2013, requesting the following information:

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.

NSHD sent the form to 119 mandatory sentinel event reporting medical facilities. These medical facilities included 59 hospitals, 59 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. All of the 119 mandatory sentinel event reporters returned the required sentinel event report summary form. These reports were then aggregated to provide a summary of the required information.

REPORT LAYOUT

The first part of the report provides information based on what was submitted by the medical facilities on their annual summary form as required by NRS 439.843. The latter section compares what was submitted on the summary forms to what has been received and recorded in the Sentinel Events Registry for 2012.

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. It also provides information regarding the medical facilities' patient safety plans and patient safety committees.

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 also provided for each. In 2012, the medical facilities indicated that they had reported a total of 1,470 sentinel events, reflecting improved reporting of sentinel events by the facilities rather than a true increase in the number of events.

Table 1 – sentinel event type totals from the 2012 sentinel event report summary forms

event type	total	percentage
abduction	**0**	**0.0%**
air embolism	**0**	**0.0%**
burn	**9**	**0.6%**
CAUTI	**343**	**23.3%**
CLABSI	**187**	**12.7%**
contaminated drug, device, or biologics	**1**	**0.1%**
device failure	**1**	**0.1%**
discharge to wrong person	**0**	**0.0%**
electric shock	**0**	**0.0%**
elopement	**10**	**0.7%**
fall	**135**	**9.2%**
HAI – other	**201**	**13.7%**
impersonation of healthcare provider	**0**	**0.0%**
intra- or post-operative death	**23**	**1.6%**
introduction of metallic object into MRI area	**2**	**0.1%**

event type	total	percentage
lost specimen	**0**	**0.0%**
maternal labor and delivery	**1**	**0.1%**
medication error	**51**	**3.5%**
neonate labor and delivery	**11**	**0.7%**
physical assault	**5**	**0.3%**
pressure ulcer	**60**	**4.1%**
restraint	**14**	**1.0%**
retained foreign object	**11**	**0.7%**
sexual assault	**4**	**0.3%**
SSI	**238**	**16.2%**
suicide	**6**	**0.4%**
surgery on wrong body part	**6**	**0.4%**
surgery on wrong patient	**1**	**0.1%**
transfusion error	**3**	**0.2%**
VAP	**34**	**2.3%**
wrong or contaminated gas	**0**	**0.0%**
wrong sperm or egg	**4**	**0.3%**
wrong surgical procedure	**2**	**0.1%**
other	**107**	**7.3%**
total	**1,470**	**100%**

A total of 107 sentinel events were categorized as 'other.' Table 2 lists the descriptions provided by the medical facilities with a total given for each category.

Table 2 – descriptions of sentinel events indicated as 'other'

'other' event descriptions	total
accidental overdose	**1**
attempted suicide	**8**
cardiopulmonary arrest immediately post-op	**1**
contaminated drug, device or biologic	**2**
death	**3**
death – post discharge	**1**
death due to choking	**1**
death in ASA Level III patient	**1**
death within 24 hours of procedure	**1**
death within 24 hours of surgery	**1**
deep vein thrombosis and pulmonary embolism	**18**
delay	**1**
delay in care	**3**
delay in treatment related to cord compression	**1**

'other' event descriptions	**total**
delay of treatment	**2**
endophthalmitis	**1**
failure to communicate	**4**
failure to monitor	**8**
failure to rescue	**2**
femoral block – wrong side x 1	**1**
inappropriate assessment	**1**
inappropriate assessment & treatment	**1**
methadone intoxication	**1**
mislabeled specimen/misreported result	**1**
near miss event	**1**
nurse outside scope of practice	**1**
outpatient surgery patient post-op death within 24 hours (post discharge)	**1**
patient swallowed foreign body requiring surgical procedure	**1**
post-op pneumonia	**1**
post-op sepsis	**1**
post-operative patients had one of either severe nausea, vomiting, weakness, low temperature, lethargic, faint feeling, arrhythmias	**6**
potential exposure	**1**
potential self-harm	**1**
procedural complication	**16**
pulmonary embolism within 72 hours of surgery	**1**
self-inflict	**1**
serious injury	**1**
sexual misconduct	**1**
staff not following procedure	**1**
transferred to higher level of care from PACU	**1**
treatment delay	**1**
treatment errors	**2**
unanticipated death	**3**
total	**107**

A total of 201 sentinel events were categorized as 'HAI – other.' Table 3 lists the descriptions provided by the medical facilities with a total given for each category.

Table 3: descriptions of sentinel events indicated as 'healthcare-acquired infection – other'

'healthcare-acquired infection – other' event descriptions	**total**
acinetobacter	**1**
clostridium difficile infection	**117**
conjunctivitis	**1**
IV site infections	**2**
MRSA	**11**
MRSA - CAUTI	**1**
MRSA - SSI	**1**
non-catheter associated urinary tract infection	**33**
non-central line associated bloodstream infection	**14**
peripheral IV bacteremia	**1**
pneumonia	**3**
pneumonia – non-vent associated	**2**
post-operative pneumonia	**3**
risk of facility acquired infection	**1**
soft tissue	**1**
UTI with foley	**2**
vancomycin-resistant *Enterococcus spp.* (VRE)	**6**
vancomycin-resistant *Enterococcus spp.* (VRE) - UTI	**1**
total	**201**

According to the summary reports provided by medical facilities, healthcare-acquired infections (HAIs), CAUTI, CLABSI, SSI, VAP, and HAI – other, were the most common types of sentinel events reported, accounting for 1,003 of the total sentinel events reported. Of these, CAUTIs was predominant at 343 reports; SSIs followed with 238 reports. Falls were the second most common at 135, and 'other' sentinel events were third at 107. Overall, HAIs amount to two-thirds (68.2%) of all sentinel events reported.

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. The facility shall also require compliance with its patient safety plan.

All medical facilities submitted some sort of document as a patient safety plan in response to the 2012 sentinel event report summary form. As was the case in 2009, 2010, and 2011, there was a great variety in the documents submitted, ranging from fully comprehensive plans to single-page documents. Patient safety plans are addressed in NRS 439.865, but statutes do not delineate the minimum requirements for a plan.

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 composed 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 composed 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, 75 facilities indicated that they had 25 or more employees, and 44 indicated that they had fewer than 25. The frequency of meetings, whether monthly or quarterly, is dependent on the number of employees at the facility. Facilities with 25 or more employees must meet *at least once each month.* Facilities with fewer than 25 employees and contractors must meet *at least once every calendar quarter*. Overall, the patient safety committees at 119 of the 119 facilities (100.0%) met as frequently as required. Among the facilities that had 25 or more employees, 75 (100.0%) of the patient safety committees met on a monthly basis. Among the facilities that had fewer than 25, 44 (100.0%) of the patient safety committees met on a quarterly basis. Tables 4 and 5 show these figures.

Table 4 – compliance with mandated meeting periodicity among facilities having 25 or more employees

monthly	total	percentage
yes	**75**	**100.0%**
no	**0**	**0.0%**
total	**75**	**100%**

Table 5 – compliance with mandated meeting periodicity among facilities having fewer than 25 employees

quarterly	total	percentage
yes	**44**	**100.0%**
no	**0**	**0.0%**
total	**44**	**100%**

The composition of the patient safety meetings is dependent on the number of employees employed by a facility. At facilities with fewer than 25 employees and contractors, *the patient safety officer, a doctor, a registered nurse, and the CEO or CFO* must be in attendance. At facilities with 25 or more employees, *the infection control officer, patient safety officer, a doctor, a registered nurse, a pharmacist, and an executive member* must be in attendance. Overall, the patient safety committees at 113 of the 119 facilities (94.9%) had the appropriate staff in attendance at the patient safety committee meetings. Among the facilities that had 25 or more employees, 97.3% had the appropriate staff in attendance. For the 2 that did not, one facility was missing a registered nurse and the other facility was missing an executive member. Among the facilities that had fewer than 25, 90.7% had the appropriate staff in attendance. In all the 4 facilities that did not, one facility was missing both a doctor and executive member, another was missing a nurse and executive member and two facilities the CEO or CFO was absent. Tables 6 and 7 show these figures.

Table 6 – compliance with mandated staff attendance among facilities having 25 or more employees

monthly	total	percentage
yes	**73**	**97.3%**
no	**2**	**2.7%**
total	**75**	**100%**

Table 7 – compliance with mandated staff attendance among facilities having fewer than 25 employees

quarterly	total	percentage
yes	**40**	**90.9 %**
no	**4**	**9.1%**
total	**44**	**100%**

COMPARISON BETWEEN SUMMARY REPORT DATA AND REGISTRY DATA

This section compares what was submitted on the summary forms to what has been received and recorded in the Sentinel Events Registry for 2012.

EVENT TYPES AND TOTALS

Similar to Table 1, Table 8 lists the types of sentinel events reportable with totals for the number reported according to both the summary forms and the reports recorded in the Sentinel Events Registry. In 2012, a total of 1,470 sentinel events were indicated as reported according to the summary forms versus 1,415 as recorded in the Sentinel Events Registry, 15 of which were determined not to be sentinel events, bringing the actual total to 1,400.

Table 8 – sentinel event type totals from the 2012 sentinel event report summary forms and Sentinel Events Registry

event type	summary	registry
abduction	0	1
air embolism	0	0
burn	9	9
CAUTI	343	315
CLABSI	187	180
contaminated drug, device, or biologics	1	2
device failure	1	1
discharge to wrong person	0	0
electric shock	0	0
elopement	10	11
fall	135	132
HAI – other	201	205
impersonation of healthcare provider	0	0
intra- or post-operative death	23	17
introduction of metallic object into MRI area	2	1
lost specimen	0	0
maternal labor and delivery	1	1
medication error	51	44
neonate labor and delivery	11	4
physical assault	5	5
pressure ulcer	60	51
restraint	14	0
retained foreign object	11	12
sexual assault	4	4
SSI	238	231
suicide	6	11

event type	summary	registry
surgery on wrong body part	6	7
surgery on wrong patient	1	0
transfusion error	3	2
VAP	34	35
wrong or contaminated gas	0	0
wrong sperm or egg	4	1
wrong surgical procedure	2	1
other	107	117
total	**1,470**	**1,400**

IMPROVEMENTS TO BE MADE

- Develop an encrypted, electronic sentinel event reporting form for use effective October 1, 2013.
- Research how to make attachments to PDF forms possible to ensure that a copy of a facility's patient safety plan is included with the form submission.
- Plan for an electronic, web-based sentinel event reporting system.

RESOURCES

The Sentinel Events Registry main page is located:
health.nv.gov/Sentinel_Events_Registry.htm

Sentinel event reporting guidance and manuals are located:
health.nv.gov/SER_guidance_and_correspondence.htm

The 2012 sentinel event reporting guidance, which explains in detail each of the sentinel event categories used in this report, is located:
health.nv.gov/SER/guidance/sentinel_event_reporting_guidance_2012-01-05.pdf

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

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

ADDITIONAL INFORMATION

For additional information regarding this publication, contact:
Darla D. Hernandez, Biostatistician
Office of Public Health Informatics and Epidemiology, Sentinel Event Registry
ddhernandez@health.nv.gov | (775) 684-4112

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