2014

Annual Sentinel Event Summary Report

October 2015

Edition 2.0

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Division of Public and Behavioral Health
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Contents

ACKNOWLEDGMENTS

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Special thanks to all the agencies and healthcare facilities that contributed to this report. This report would not be possible without your support, cooperation and dedication to improve patients' safety in Nevada.

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PURPOSE

Legislation passed during the 2009 Legislative Session requires the DPBH to compile the annual Sentinel Event report summaries and submit the compilation to the State Board of Health each year by June 1. It is intended for use by legislators and the public, containing summary and individual reports submitted by facilities to the Sentinel Event Registry (SER). This is the sixth annual summary report to be 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 intends to help readers not only see the improvement and trends from year to year, but also help readers identify areas for improvement. It is expected that healthcare consumers can manage their healthcare decisions better, healthcare providers can learn from the experiences and improve their patient safety programs, and healthcare organizations and regulators will have the appropriate and adequate information to assess accountability of healthcare facilities in Nevada.

SENTINEL EVENT DEFINED

As a result of Assembly Bill 28 (AB 28), which became 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 (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. This report covers the usage of both definitions of a Sentinel Event as defined by Assembly Bills 59 and 28 during 2014.

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, Nevada Administrative Code (NAC) 439.840(2), NRS 439.845(2)b, and NRS 439.855 , 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 (Part 1 and Part 2). 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. All but one mandatory Sentinel Event reporting medical facility returned the required summary form. The facility closed prior to returning a summary submission. These reports were then aggregated to provide a summary of the required information.

REPORT LAYOUT

There are two parts of major data analysis included in this report. The first part of the data analysis is based on what was submitted by the medical facilities on their annual summary form as required by NRS 439.843 . The latter part includes information received and recorded in the Sentinel Events Registry, as well as the comparison with the annual summary data and historic data to identify trends and differences.

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.

I) 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 event type. In 2014, the medical facilities indicated that they had reported a total of 300 Sentinel Events.

Table 1: Sentinel Event type totals from the 2014 Sentinel Event report summary forms

No.	Event Type	Totals	Percentage
1	Abduction	1	0.33%
2	Air Embolism	0	0.00%
3	Burn	7	2.33%
4	Contaminated Drug, Device, or Biologic	6	2.00%
5	Device Failure	6	2.00%
6	Discharge to Wrong Person	1	0.33%
7	Electric Shock	0	0.00%
8	Elopement	6	2.00%
9	Failure to Communicate Test Result	6	2.00%
10	Fall	105	35.00%
11	Impersonation of Healthcare Provider	2	0.67%
12	Intra-or Post-Operative Death	12	4.00%
13	Introduction of Metallic Object into MRI area	0	0.00%
14	Lost Specimen	1	0.33%
15	Maternal Labor or Delivery	2	0.67%
16	Medication Error	8	2.67%
17	Neonate Labor or Delivery	1	0.33%
18	Physical Assault	27	9.00%
19	Pressure Ulcer	66	22.00%
20	Restraint	2	0.67%
21	Retained Foreign Object	18	6.00%
22	Sexual Assault	5	1.67%
23	Suicide	7	2.33%
24	Surgery on Wrong Body Part	4	1.33%
25	Surgery on Wrong Patient	1	0.33%
26	Transfusion Error	2	0.67%
27	Wrong or Contaminated Gas	2	0.67%
28	Wrong Sperm or Egg	0	0.00%
29	Wrong Surgical Procedure	2	0.67%
	Total	**300**	**100.00%**

Figure1: Sentinel Events by Event Type in 2014 (from the summary report form)

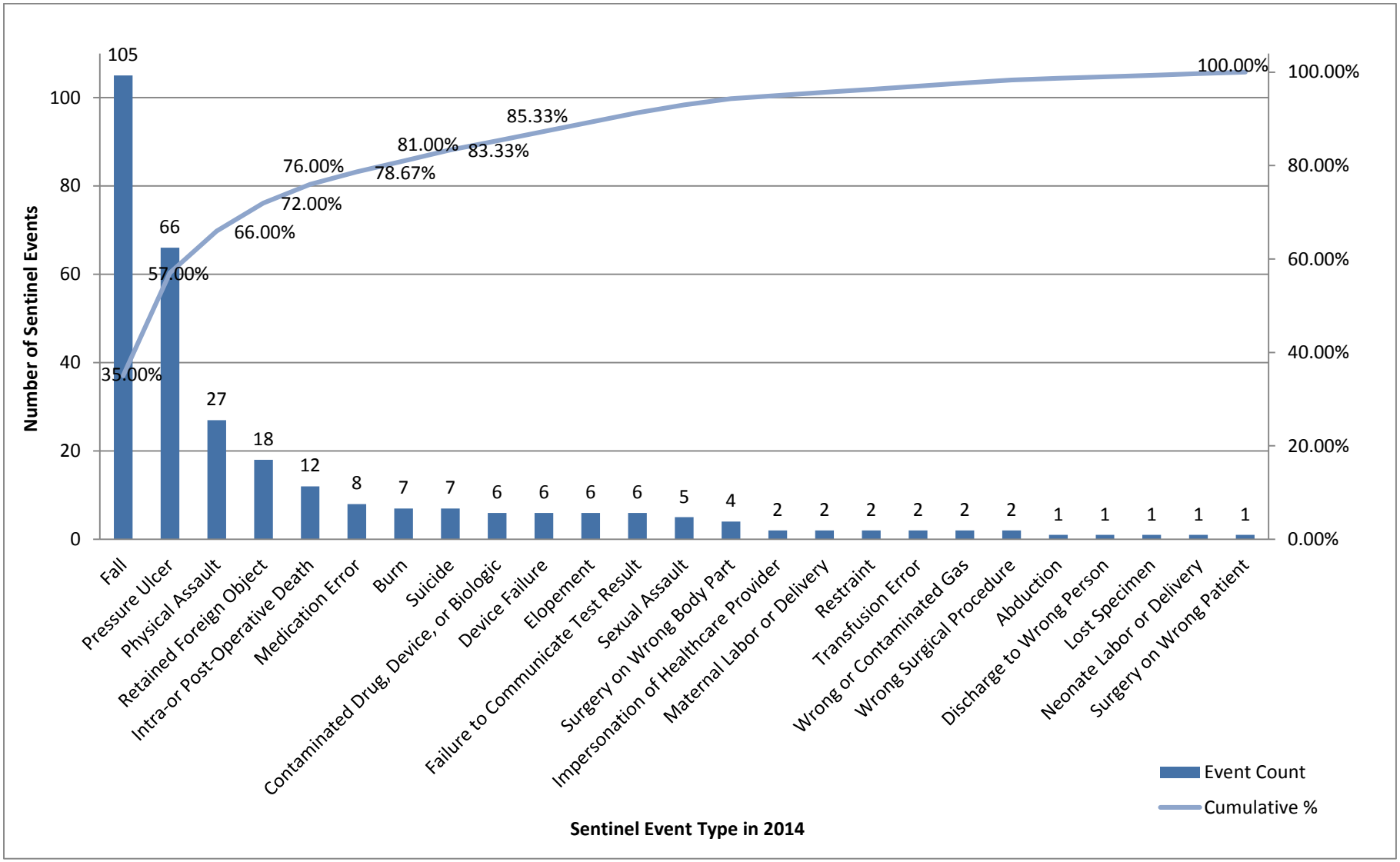
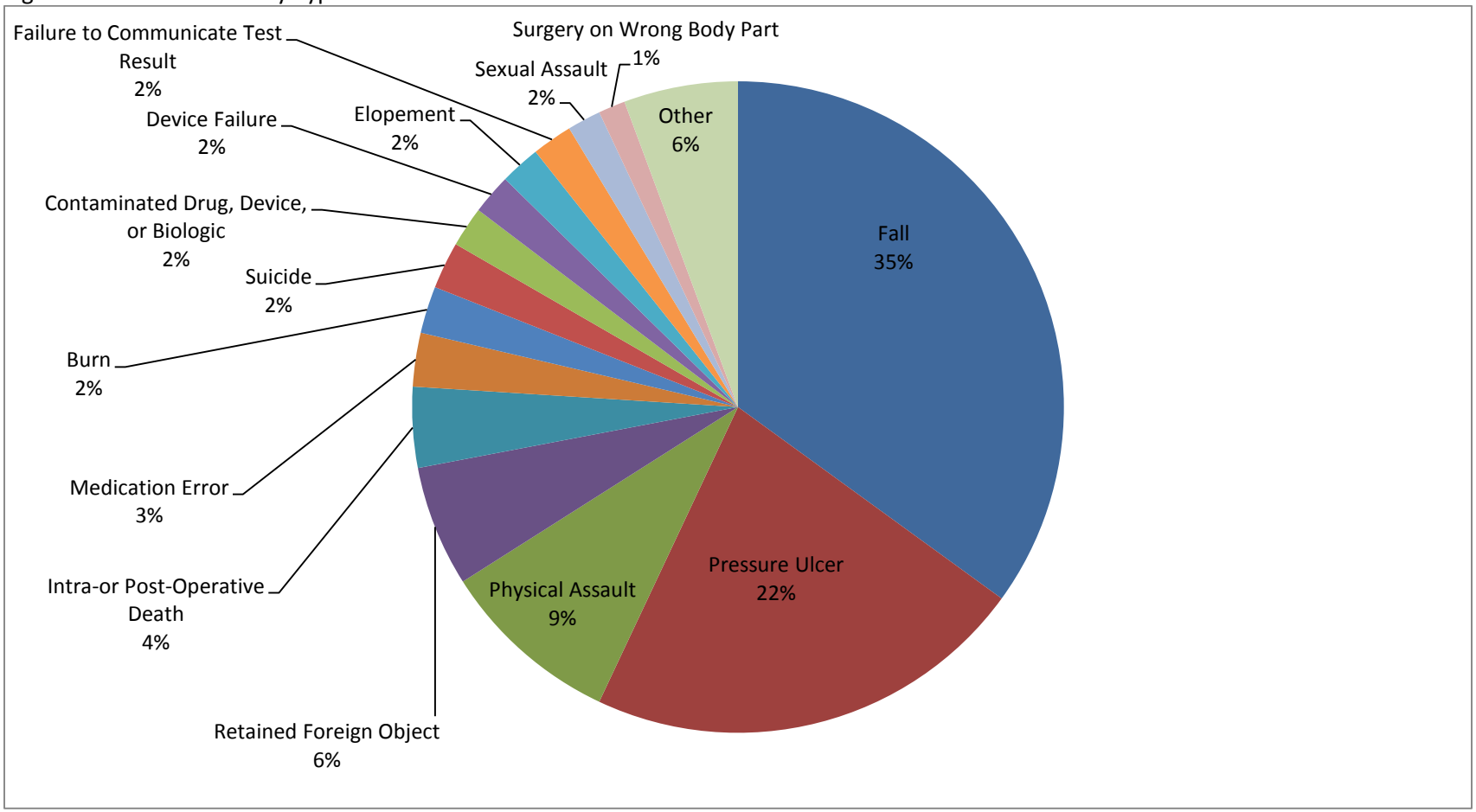


Table 1 and Figure 1 show the top four Sentinel Events in 2014 were:

- Fall (150, 35%)
- Pressure ulcer (66, 22%)
- Physical assault (27, 9%)
- Retained foreign object (18, 6%)

These four event types constitute 72% of the total events. Figure 2 below illustrates the portion of each event type.

Figure 2: Sentinel Events by Type in 2014



II) Number and Percentage of Falls (2011-2014)

From the statewide summary analysis in Table 1, Figure 1, and Figure 2, falls contributed the highest number of events in 2014. Table 2 shows the number of falls reported by year since 2011.

Table 2: Number of falls in 2011-2014

Year	2011	2012	2013	2014
Fall	135	135	109	105

III) Sentinel Events by Facility Type in 2014

Table 3 indicates that hospitals were the major facilities contributing to most Sentinel Events in 2014 with 271 out of 300 events. Hospitals accounted for 90.33% of total Sentinel Events.

Table 3: Sentinel Events by Facility Type

Facility Type	HOS	ASC	RUH	Total
Count	271	25	4	**300**
Percentage	90.33%	8.33%	1.33%	

Note: HOS: Hospitals ASC: Ambulatory Surgical Centers RUH: Rural Hospitals

REGISTRY DATA ANALYSIS AND COMPARISON BETWEEN SUMMARY REPORT DATA AND REGISTRY DATA

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

I) Event Types and Totals

Similar to Table 1, Table 4 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 2014, a total of 300 Sentinel Events were reported according to the summary forms versus 307 as recorded in the Sentinel Events Registry. Twenty (20) of these were determined not to be Sentinel Events, bringing the actual total to 287.

Table 4 – Sentinel Event Type Totals from the 2014 Sentinel Event Report Summary Forms and Sentinel Events Registry

Event Type	Totals from Summary Report	Totals from Registry Database	Difference*
Fall	105	98	7
Pressure Ulcer	66	69	-3
Physical Assault	27	28	-1
Retained Foreign Object	18	16	2
Intra-or Post-Operative Death	12	13	-1
Medication Error	8	7	1
Burn	7	5	2
Suicide	7	7	0
Contaminated Drug, Device, or Biologic	6	4	2
Device Failure	6	5	1
Elopement	6	6	0
Failure to Communicate Test Result	6	6	0
Sexual Assault	5	4	1
Surgery on Wrong Body Part	4	3	1
Impersonation of Healthcare Provider	2	1	1
Maternal Labor or Delivery	2	3	-1
Restraint	2	2	0
Transfusion Error	2	0	2
Wrong or Contaminated Gas	2	2	0
Wrong Surgical Procedure	2	2	0
Abduction	1	0	1
Discharge to Wrong Person	1	1	0
Lost Specimen	1	1	0
Neonate Labor or Delivery	1	1	0
Surgery on Wrong Patient	1	2	-1
Procedure Complications	0	1	-1
Total	**300**	**287**	**13**

Note: 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.

II) Total Sentinel Events Summary Data vs. Registry Data (2011-2014)

From Table 5 and Figure 3, readers will notice that total number of Sentinel Events from the summary forms and the registry reports all show the same trends from 2011-2014. The events number increased from 2011 to 2012, and slightly decreased from 2012 to 2013. A linear decrease with a steep slope from 2013 to 2014 was shown in the trend line with the decreasing rate of 77%. This enormous change from 2013 to 2014 was the result of a change in the Sentinel Event definition effective October 1, 2013.

Sentinel Events, categorized as “Other,” “HAI-Other,” “CAUTI,” “CLABSI,” “SSI,” and “VAE,” were only reported to the National Healthcare Safety Network (NHSN) instead of double reporting into the SER and NHSN as in previous years. Detailed information can be found in Table 5.

Table 5: Total Events Summary vs. Registry (2011-2014)

Year	**2011**	**2012**	**2013**	**2014**
Not Sentinel Events	12	16	14	20
Other Events	88	107	85	0
HAI-Other Event	205	201	277	0
CAUTI	148	343	241	0
CLABSI	149	187	176	0
SSI	171	238	192	0
VAE	24	34	6	0
Registry Sentinel Events	1057	1423	1339	287
Summary Sentinel Events	1060	1470	1268	300

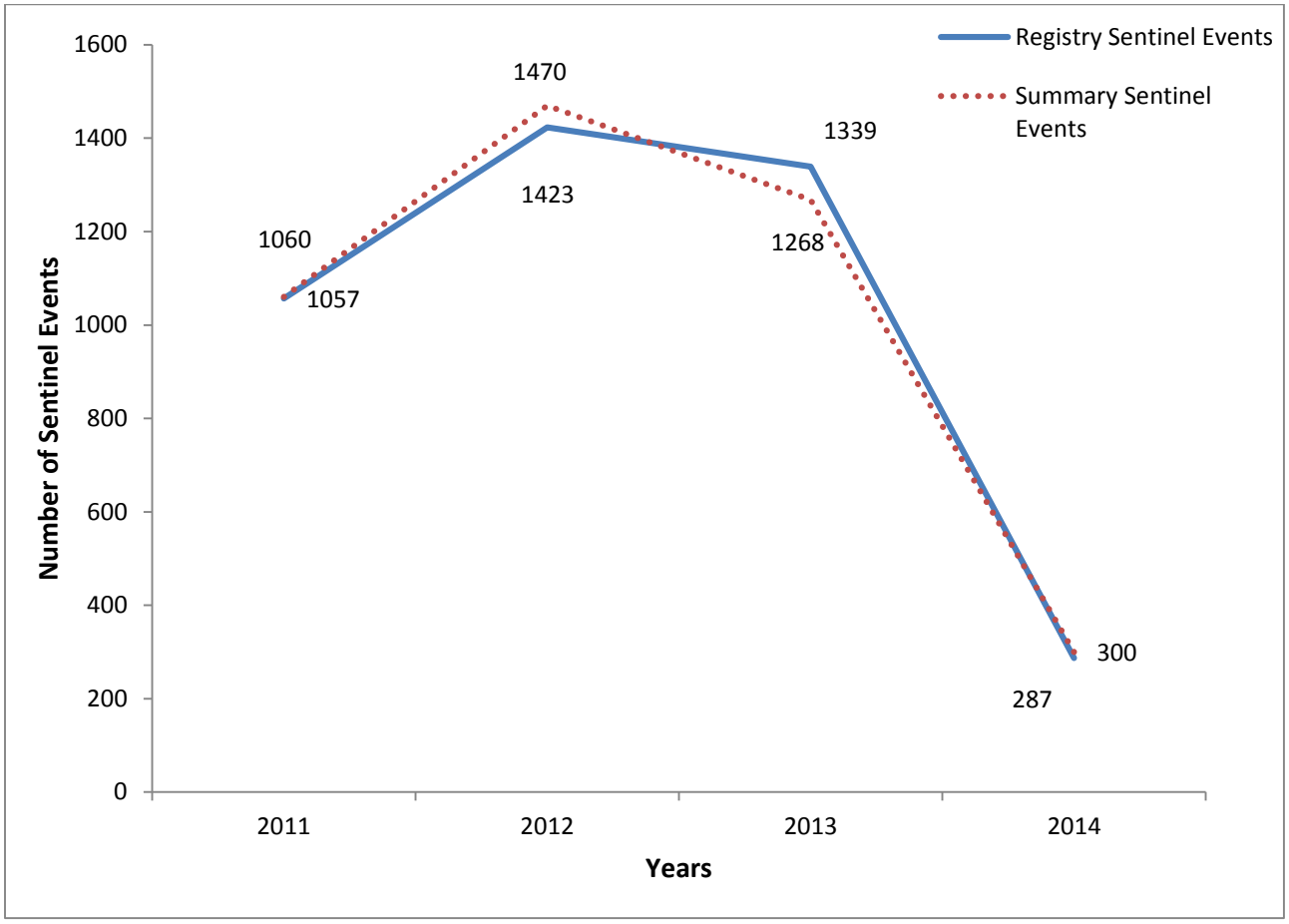
Remark:

1. Not Sentinel Event: Upon investigation, it was determined not to be a Sentinel Event after the form 1 submission.
2. HAI: Healthcare-Associated Infection.
3. CAUTI: Catheter-Associated Urinary Tract Infection.
4. CLABSI: Central Line-Associated Bloodstream Infection.
5. SSI: Surgical Site Infection.
6. VAE: Ventilator-Associated Event.

Registry Sentinel Events and Summary Sentinel Events include all Sentinel Events from the registry database including “Other,” “HAI-other,” “CAUTI,” “CLABSI,” “SSI,” and, “VAE” from 2011 to 2013. However, these event types were no longer required to be reported to SER in 2014.

In 2014, there were 287 Sentinel Events recorded in the SER database. However, these facilities submitted a total of 300 Sentinel Events in their summary report. Ideally, these two numbers should be the same. The difference details are listed in Table 4.

Figure 3: Total Sentinel Events Summary vs. Registry (2011-2014)



III) Primary Contributing Factors in 2014

There were 727 primary contributing factors that contributed to Sentinel Events in 2014. These factors include patient-related, staff-related, communication/documentation, organization, technical, environment, and other primary contributing factors. Table 6 and Figure 4 show the top three primary contributing factors as:

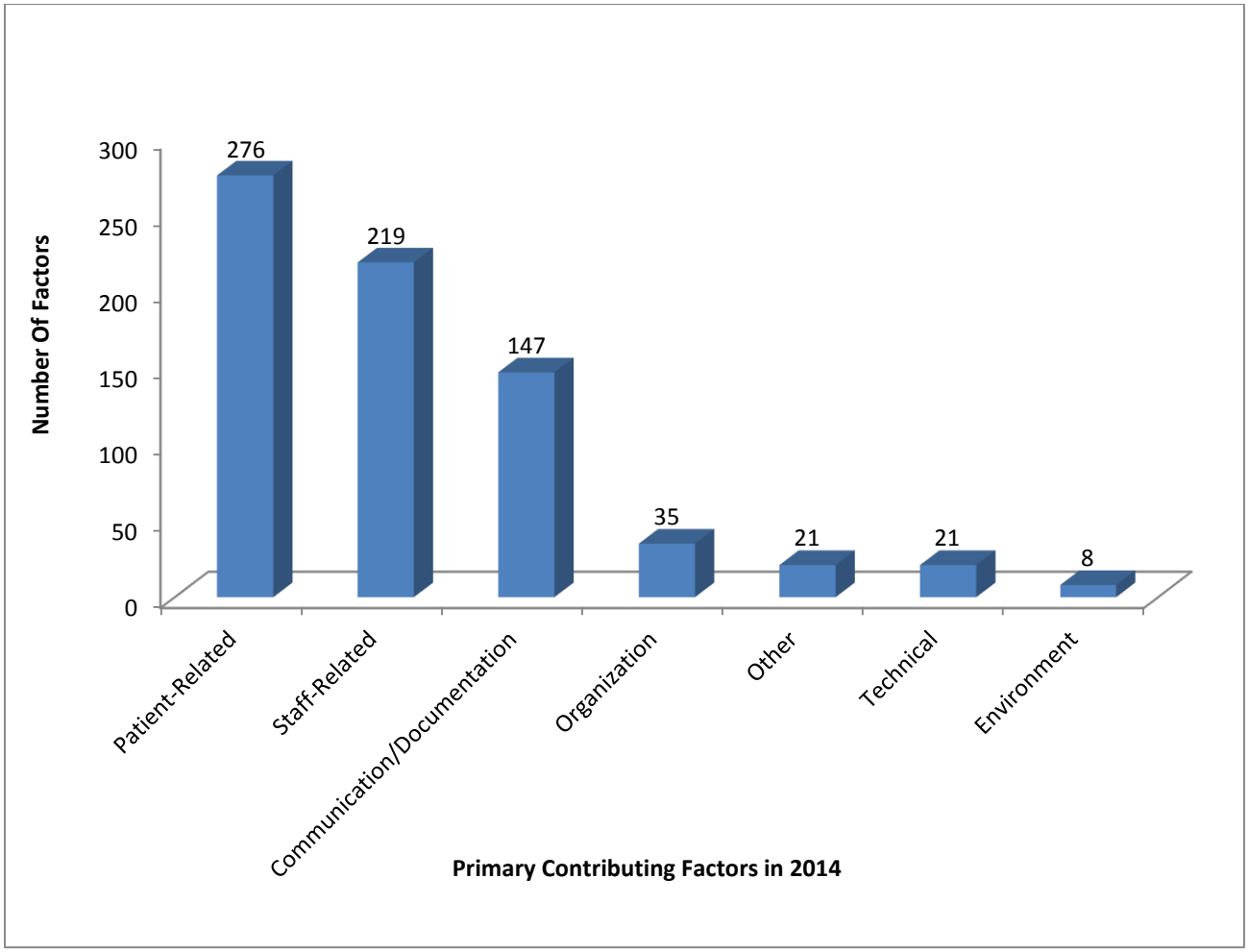
- Patient-Related (276, 37.96%)
- Staff-Related (219, 30.12%)
- Communication/Documentation Related (147, 20.22%).

These three factors contributed to 88.31% of the total primary contributing factors in 2014.

Table 6: Primary Contributing Factors in 2014 (according to the registry database)

Primary Contributing Factors	Count	Percentage	Cum. Percentage
Patient Related	276	37.96%	37.96%
Staff-Related	219	30.12%	68.09%
Communication/Documentation	147	20.22%	88.31%
Organization	35	4.81%	93.12%
Technical	21	2.89%	98.90%
Environment	8	1.10%	100.00%
Other	21	2.89%	96.01%
Total	**727**	**100%**	

Figure 4: Primary Contributing Factors in 2014



IV) Detailed Primary Contributing Factors in 2014

The detailed primary contributing factors in 2014 are displayed in Table 7. From the table, readers will notice that the factor Clinical Decision/Assessment contributed 88 events with 12.10% of total events; Frail/Unsteady contributed 84 events with 11.55% of total events; and Failure to Follow Policy/or Procedure contributed 78 events accounting for 10.73% of total events.

Table 7: Detailed Primary Contributing Factors in 2014

Detailed Contributing Factors	Count	Percent	Cum. Percent
Clinical Decision/Assessment	88	12.10%	12.10%
Frail/Unsteady	84	11.55%	23.66%
Failure to Follow Policy and/or Procedure	78	10.73%	34.39%
Physical Impairment	55	7.57%	41.95%
Non-Compliant	49	6.74%	48.69%
Hand-Off/Teamwork/Cross-Coverage	44	6.05%	54.75%
Lack of Communication	42	5.78%	60.52%
Clinical Performance/Administration	39	5.36%	65.89%
Confusion	39	5.36%	71.25%
Lack of/Inadequate Documentation	31	4.26%	75.52%
Verbal Communication - Inadequate	23	3.16%	78.68%
Medicated	17	2.34%	81.02%
Psychosis	16	2.20%	83.22%
Training Inadequate/Not Done	16	2.20%	85.42%
Iatrogenic Error(s)	11	1.51%	86.93%
Inappropriate/No Policy/Process	10	1.38%	88.31%
Self-Harm	10	1.38%	89.68%
All the Other Factors	75	10.32%	100.00%
Total	**727**	**100%**	

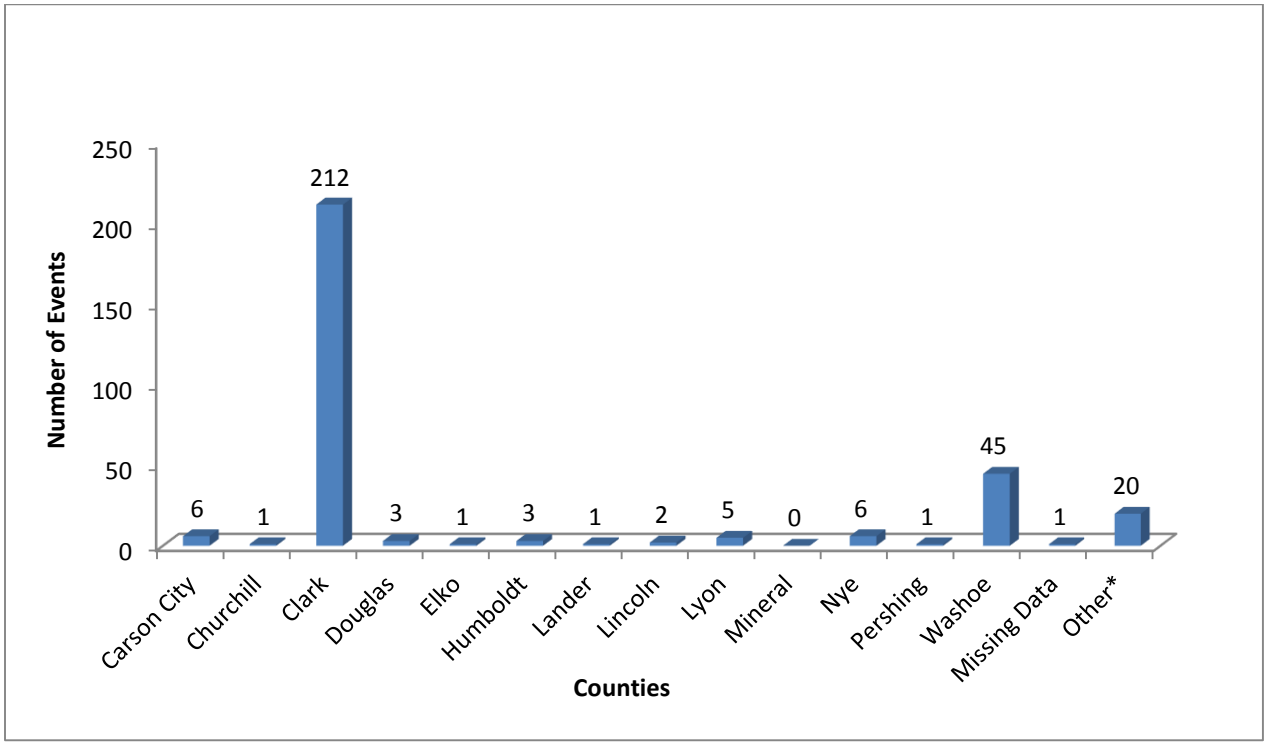
V) Sentinel Events by County in 2014

Table 8 and Figure 5 show that Clark County had 212 events and Washoe County had 45 events, representing 69.06% and 14.66% of the total events respectively in 2014. These two counties contributed a total of 257 out of 307 events (83.71%). 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 (inclusive of all events from SER database)

County	Number of Events	Percent
Carson City	6	1.95%
Churchill	1	0.33%
Clark	212	69.06%
Douglas	3	0.98%
Elko	1	0.33%
Humboldt	3	0.98%
Lander	1	0.33%
Lincoln	2	0.65%
Lyon	5	1.63%
Mineral	0	0.00%
Nye	6	1.95%
Pershing	1	0.33%
Washoe	45	14.66%
Missing Data	1	0.33%
Other* (Patients were from other states instead of Nevada)	20	6.51%
Total	**307**	**100%**

Figure 5: Sentinel Events by County in 2014



Other*: Patients were from other states instead of Nevada.

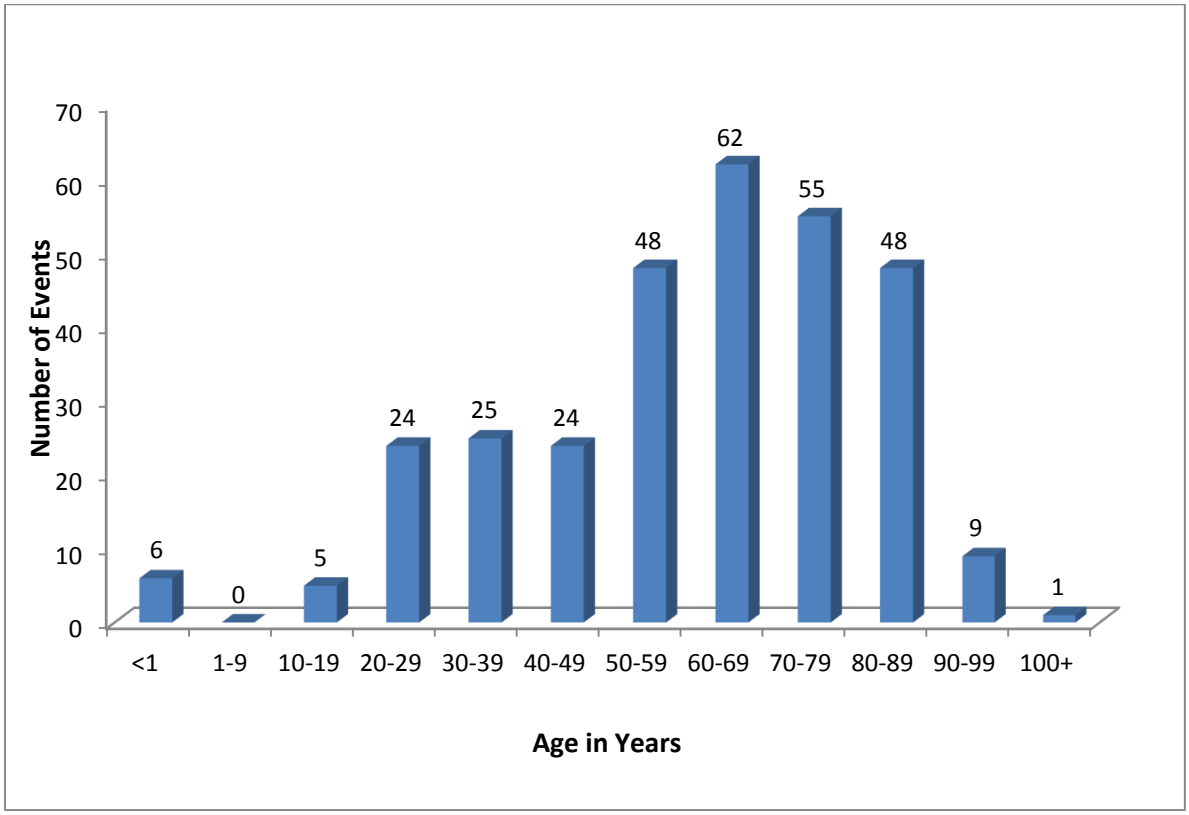
VI) Sentinel Events by Age in 2014

Table 9 and Figure 6 below show that 213 Sentinel Events occurred to patients whose ages ranged between 50 and 89 years old, which accounts for 69.83% of the total events.

Table 9: Sentinel Events by Age in 2014 (inclusive of all the events from the SER database)

Patient's Age	Count	Percent
<1 year old	6	1.95%
1-9 years old	0	0.00%
10-19 years old	5	1.63%
20-29 years old	24	7.82%
30-39 years old	25	8.14%
40-49 years old	24	7.82%
50-59 years old	48	15.64%
60-69 years old	62	20.20%
70-79 years old	55	17.92%
80-89 years old	48	15.64%
90-99 years old	9	2.93%
100+ years old	1	0.33%
Total	**307**	**100%**

Figure 6: Sentinel Events by Age in 2014



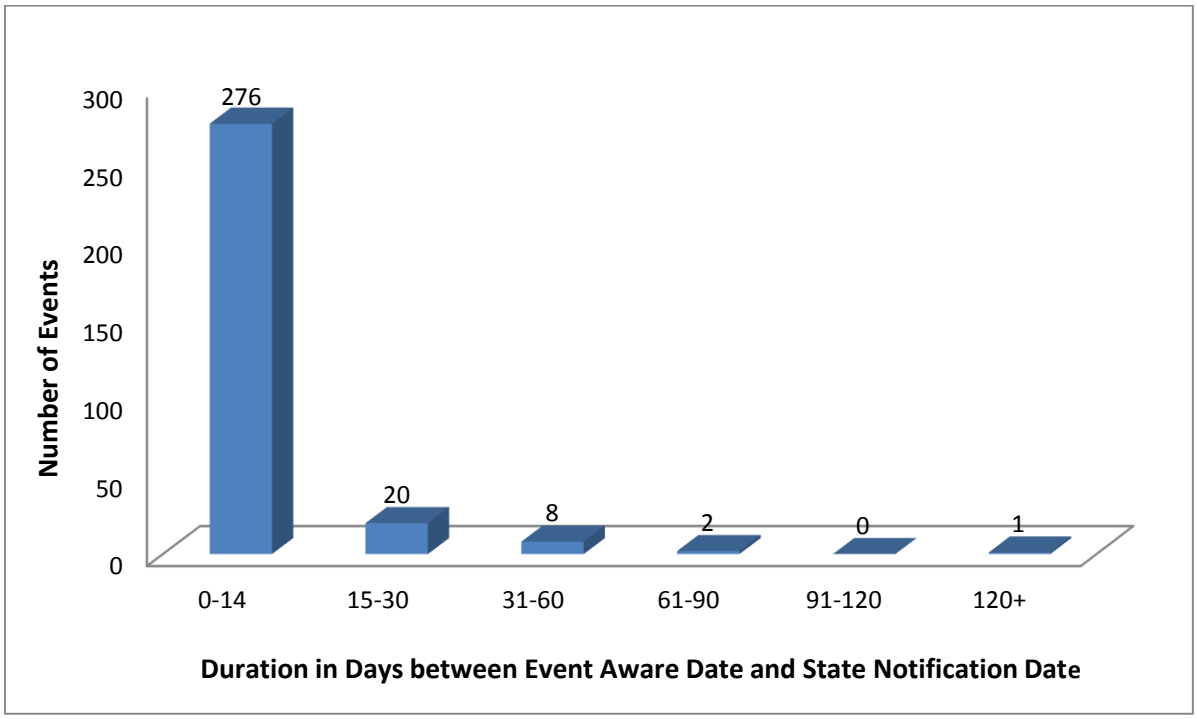
VII) Duration in Days between Event Aware Date and Facility State Notification Date

According to NRS 439.835, facilities must notify the SER within 13 days or 14 days depending upon if the patient safety officer or another healthcare worker discovers the event. Table 10 and Figure 7 show most facilities (276, 89.9%) notified the SER within 14 days after the event. There were 20 events (6.51%) that were reported to the SER between 15 days and 30 days after the event, and 11 events that were reported more than 30 days after the event.

Table 10: Duration between Event Aware Date and State Notification Date (inclusive of all the events from the SER database)

Duration	Count	Percent
0-14 days	276	89.90%
15-30 days	20	6.51%
31-60 days	8	2.61%
61-90 days	2	0.65%
91-120 days	0	0.00%
120+ days	1	0.33%
Total	**307**	**100%**

Figure 7: Duration between Event Aware Date and State Notification Date in 2014 (inclusive of all the events from the SER database)



VIII) 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 its 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 out an email to remind the medical facilities when the SER Part 2 form will be due.

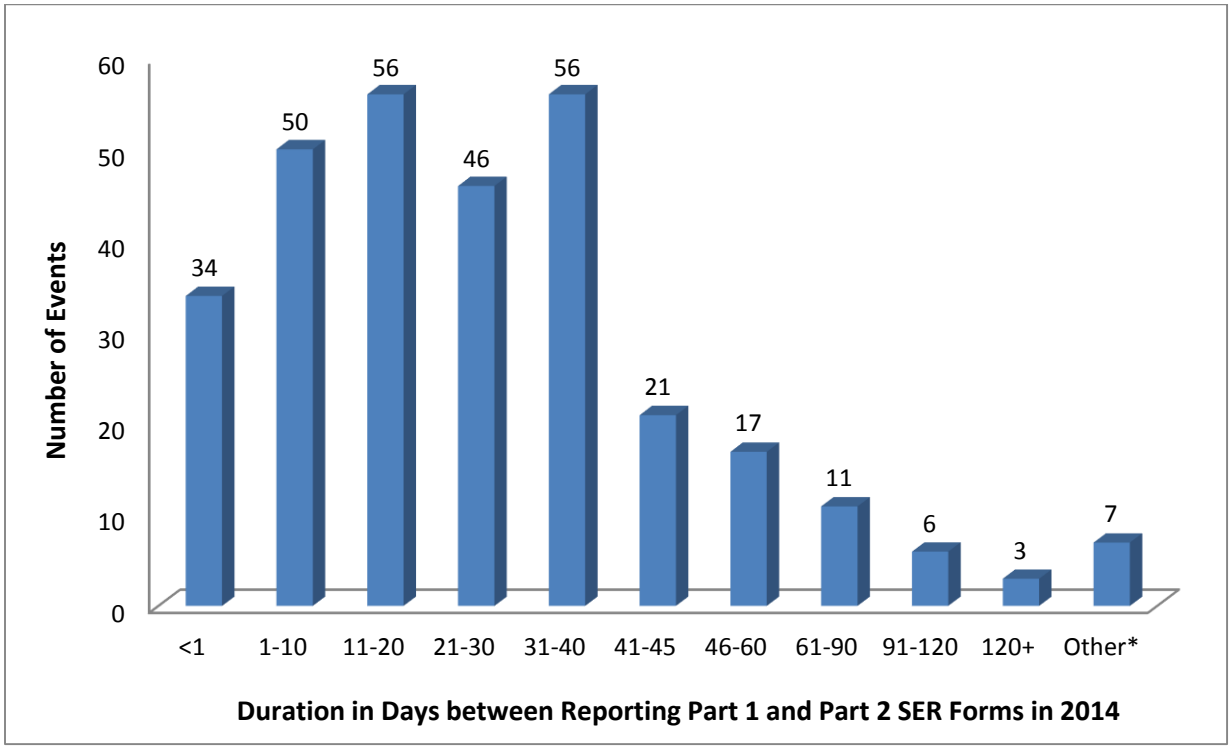
Table 11 and Figure 8 illustrate that most facilities submitted their Part 2 form within 45 days after submitting the Part 1 form. However, there were 37 out of 307 (12.05%) events when a facility submitted the SER Part 2 after the 45 days deadline passed. There were also 3 events when facilities submitted the Part 2 form more than 120 days after submitting the Part 1 form. Seven (7) 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	Count	Percent
<1 day	34	11.07%
1-10 days	50	16.29%
11-20 days	56	18.24%
21-30 days	46	14.98%
31-40 days	56	18.24%
41-45 days	21	6.84%
46-60 days	17	5.54%
61-90 days	11	3.58%
91-120 days	6	1.95%
120+ days	3	0.98%
Other*	7	2.28%
Total Events	**307**	**100%**

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

Figure 8: Duration in Days between Reporting Part 1 and Part 2 SER Forms in 2014



Section summary:

Comparing the data analysis from registry database and the summary report, readers can find:

- Total numbers of Sentinel Events dramatically decrease from 2013 to 2014. The decreasing rate for both Registry data and summary data were 77% due to the change of the law. The new Sentinel Event law is more defined when compared to the broadness of the previous Sentinel Event law. Events categorized as HAI-other, CAUTI, CLABSI, SSI, and VAE were reported to NHSN, instead of being reporting to the SER.
- The top 3 primary contributing factor for the Sentinel Events in 2014 are:
  - Patient related factor (276, 37.96%)
  - Staff related factor (129, 30.12%)
  - Communication/Documentation (147, 20.22%)
- The detailed primary contributing factors for the Sentinel Events in 2014 are:
  - Clinical Decision/Assessment (88, 12.10%)
  - Frail/Unsteady (84, 11.55%)
  - Failure to Follow Policy/Procedure (78, 10.73%)
- Clark County and Washoe County contributed the most events since these two counties are the most populated counties in Nevada.
  - Clark County (212, 69.06%)
  - Washoe County (45, 14.66%)
- Patients' age ranging from 50 to 89 years old contributed to majority of the events in 2014 (213, 69.38%).

- There were 276 (89.9%) facilities that notified the SER within 14 days of the Sentinel Event occurring, and 31 (10.1%) facilities that notified the SER more than 14 days after the occurrence of the Sentinel Event.
- There were 85.67% of facilities who submitted the SER Part 2 form within 45 days of submitting Part 1, and 12.05% of facilities who exceeded the 45 day period.

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 2014 Sentinel Event report summary form. As was the case from 2009 to 2013, 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, 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 and contractors 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, 80 facilities indicated they had 25 or more employees, and 45 indicated that they had fewer than 25. Overall, the patient safety committees at 123 of the 125 facilities (98.4%) met as frequently as required. Among the facilities that had 25 or more employees, 79 (98.75%) of the patient safety committees met on a monthly basis. Among the facilities that had fewer than 25 employees, 44 (97.78%) of the patient safety committees met on a quarterly basis. Table 12 shows these figures.

Table 12 – Compliance with Mandated Meeting Periodicity among Facilities

Facilities Having 25 or More Employees and Contractors			**Facilities Having Fewer Than 25 Employees and Contractors**		
Monthly Meeting	**Total Facilities**	**Percentage**	**Quarterly Meeting**	**Total Facilities**	**Percentage**
Yes	79	98.75%	Yes	44	97.78%
No	1	1.25%	No	1	2.22%
Total	**80**	**100.00%**	**Total**	**45**	**100.00%**
One facility did not have monthly meeting.			One facility did not have quarterly meeting.		

All patient safety committees had the appropriate staff in attendance at the patient safety committee meetings. Table 13 shows this in greater detail.

Table 13 – Compliance with Mandated Staff Attendance among Facilities

Facilities Having 25 or More Employees and Contractors			Facilities Having Fewer Than 25 Employees and Contractors		
Monthly Meeting	**Total Facilities**	**Percentage**	**Quarterly Meeting**	**Total Facilities**	**Percentage**
Yes	80	100.00%	Yes	45	100.00%
No	0	0.00%	No	0	0.00%
Total	**80**	**100.00%**	**Total**	**45**	**100.00%**

CONCLUSION

Sentinel Event reporting focuses on identifying and deterring 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 the situation from occurring in the future. The system was designed for continuous improvement to the quality of services by the facilities learning experience through the course of the event in order to establish better preventative practices.

Improving patient safety is the responsibility of all stakeholders in the healthcare system which includes patients, providers, health professionals, organizations, and government. From the data analysis, readers can see there was an improvement in 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.

The Sentinel Events program will 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 the preventable incidents, in order to help facilitate the improvement in the quality of healthcare for citizens in Nevada.

IMPROVEMENTS TO BE MADE

- Develop an encrypted, electronic Sentinel Event reporting form to improve upon the existing electronic form that requires fax submission and to strive to implement web-based submission in compliance with NRS 237.360.

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

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