Year Events Occurred

SENTINEL EVENT REPORT SUMMARY FORM

Name of Person Completing Summary

Name of Facility

Facility License Number

Patient Safety Officer Name

Enter the number of sentinel events reported for each event type category below. For categories having no reported sentinel events over the calendar year, you may leave them blank. If either of the 'other' categories are used, please also specify the type(s) of event(s) in the text box provided.

Surgery on Wrong Body Part	**Suicide**	**Electric Shock**
Surgery on Wrong Patient	**Medication Error**	**Wrong or Contaminated Gas**
Wrong Surgical Procedure	**Transfusion Error**	**Burn**
Retained Foreign Object	**Maternal Labor or Delivery**	**Restraint**
Intra- or Post-Operative Death	**Neonate Labor or Delivery**	**Introduction of Metallic Object into MRI Area**
Contaminated Drug, Device, or Biologic	**Fall**	**Impersonation of Healthcare Provider**
Device Failure	**Pressure Ulcer**	**Abduction**
Air Embolism	**Wrong Sperm or Egg**	**Sexual Assault**
Discharge to Wrong Person	**Lost Specimen**	**Physical Assault**
Elopement	**Failure to Communicate Test Result**	**Other**

If "other" please specify the type(s) of event(s):

Total Sentinel Events that Occurred in 2015 0

PATIENT SAFETY COMMITTEE

Number of Employees

If employee count is greater than or equal to 25, please fill out section A below.
If less than 25 employees, fill out section B.

Section A

For facilities that have more than or equal to 25 employees, their Patient Safety Committee must consist of the following people. Please fill in the **names** of each.

Infection Control Officer:

Patient Safety Officer:

MD

RN

Pharmacist

Executive Member

Does your Patient Safety Committee meet AT LEAST monthly?

Yes No

Section B

For facilities that have less than 25 employees and/or contractors, their Patient Safety Committee must consist of the following people. Please fill in the **names** of each.

Patient Safety Officer:

MD

RN

CEO or CFO

Does your Patient Safety Committee meet AT LEAST quarterly?

Yes No

Summarize the activities of the committee.

Once completed please save and email this form to ser@health.nv.gov. Please ensure that you also **attach a copy of your facility's patient safety plan** and send to ser@health.nv.gov.

Please check box below.

A copy of the patient safety plan will accompany this form.

This form must be completed by March 1, 2016