

State of Nevada

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Sentinel Events

Past to Present

Department of Health and Human Services
Division of Public and Behavioral Health
Office of Public Health Informatics and Epidemiology
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Edition 1.1
Presented by Morgan Friend

What is a Sentinel Event?

- [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.”

What will be a Sentinel Event? Effective October 1, 2013

- 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.” (NQF) The report published by the National Quality Forum has gone through three iterations, 2002, 2006 and 2011.

Injury defined in NQF Appendix B Glossary

- “as used in this report, has a broad meaning. It includes physical or mental damage that substantially limits one or more of the major life activities of an individual in the short term, which may become a disability if extended long term. Further, injury includes a substantial change in the patient’s long-term risk status such that care or monitoring, based on accepted national standards, is required that was not required before the event. (of note, states and other entities may use alternate definitions for the term “disability.”) (NQF, 2011: B-2, B-3).”

Serious defined in NQF Appendix B Glossary

- “describes an event that can result in death, loss of a body part, disability, loss of bodily function, or require major intervention for correction (e.g., higher level of care, surgery) (NQF, 2011: B-4).”

Which Medical Facility Types are required to report Sentinel Events?

- Hospitals
- Surgical Centers for Ambulatory Patients
- Obstetric Centers
- Independent Centers for Emergency Medical Care

What is the purpose of the Sentinel Event Registry?

- The Sentinel Events Registry is a database used to collect, analyze, and evaluate such adverse events.

What is the intent of the Sentinel Event Registry?

- 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.

The NRS regarding the Sentinel Event Registry

- [NRS 439.835](#) requires that medical facilities report sentinel events to the Division of Public and Behavioral Health (DPBH).

What is the purpose of reporting a Sentinel Event?

“The Purpose of the NQF-endorsed list of Serious Reportable Events in Healthcare is to facilitate uniform and comparable public reporting to enable systematic learning across healthcare organizations and systems and to drive systematic national improvements in patient safety based on what is learned – both about the events and about how to prevent their recurrence (NQF, 2011: 1).”

Original vision of Sentinel Events

“The Serious Reportable Events (SREs) were originally envisioned as a set of events that might form the basis for a national state-based reporting system, and they continue to serve that purpose. Additionally, they have been used or adapted by national entities with the goal of illuminating such events to facilitate learning and improvement (NQF, 2011: 1).”

Current Types of Sentinel Events

- Surgery on wrong body part
- Surgery on wrong patient
- Wrong surgical procedure
- Retained foreign object
- Intra- or post-operative death
- Contaminated drug, device, or biologic
- Device Failure
- Air embolism
- Discharge to wrong person
- Elopement
- Suicide
- Medication error
- Transfusion error
- Maternal labor or delivery
- SSI
- Neonate labor or delivery
- Fall
- Pressure Ulcer
- Wrong sperm or egg
- Lost Specimen
- Electric shock
- HAI-Other
- Other
- Wrong or contaminated gas
- Burn
- Restraint
- Introduction of metallic object into MRI area
- Impersonation of healthcare provider
- Abduction
- Sexual assault
- Physical assault
- CLABSI
- CAUTI
- VAP

The categories of Sentinel Events effective October 1, 2013

- **Surgical or Invasive Procedure Events**
- **Product or Device Events**
- **Patient Protection Events**
- **Care Management Events**
- **Environmental Events**
- **Radiologic Events**
- **Potential Criminal Events**

Past to Present Sentinel Event Summary

Pre-AB28	Post-AB28	Benefits
Infinite possible sentinel events	Finite list of sentinel events	Reporters know exactly what they have to report
Ambiguous, undefined terms used in the definition	Clear definitions with extensive descriptions and a glossary of terms	The more robust NQF documentation will aid reporters in more confidently determining whether an incident qualifies as a sentinel event
Based on The Joint Commission definition, which has never been updated	Based on the National Quality Forum definition, which has been updated twice	The sentinel event categories are more likely to reflect advances in medical research and techniques, making them timely and relevant to track
Duplicative of reporting some events to both NHSN and SER	Dramatic reduction in duplicative reporting; some events could still be reported to both	Time, effort and expense saved filling out duplicative reports
Inconsistent, subjective reporting due to ambiguities and undefined terms	More easily auditable reporting and standardized reporting	Facilities will be able to reliably assess how they compare to other facilities and interstate comparisons will show how the state fares relative to other states

Kvam: 2013

Current Categories of Sentinel Events Defined

Surgical or Invasive Procedure Events

- A.** Surgery or other invasive procedure performed on the wrong site
- B.** Surgery or other invasive procedure performed on the wrong patient
- C.** Wrong surgical or other invasive procedure performed on a patient
- D.** Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- E.** Intraoperative or immediately postoperative/post procedure death in an American Society of Anesthesiologists Class 1 patient.

Examples of Sentinel Events

Surgical or Invasive Procedure Events

- “Surgery or other invasive procedure on the right body part but on the wrong location/site on the body (NQF, 2011: A-2).”
- “Surgical procedures (whether or not completed) initiated on one patient intended for a different patient (NQF, 2011: A-3).”
- “Insertion of the wrong medical implant into the correct surgical site(NQF, 2011: A-3).”

Product or Device Events

- A.** Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
- B.** Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
- C.** Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.

Examples of Sentinel Events

Product or Device Events

- “Occurrences related to use of improperly cleaned or maintained device (NQF, 2011: A-5).”
- “High-risk procedures, other than neurosurgical procedures, that include, but are not limited to, procedures involving the head and neck, vaginal delivery and caesarean section, spinal instrumentation procedures, and liver transplantation (NQF, 2011:A-6).”
- “Low-risk procedures, including those related to lines placed for infusion of fluids in vascular space (NQF, 2011: A-6).”

Patient Protection Events

- A.** Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
- B.** Patient death or serious injury associated with patient elopement (disappearance)
- C.** Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a health care setting.

Care Management Events

- A.** Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- B.** Patient death or serious injury associated with unsafe administration of blood products
- C.** Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
- D.** Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy

Care Management Events

- E.** Patient death or serious injury associated with a fall while being cared for in a healthcare setting
- F.** Any Stage 3, Stage 4, and un-stage-able pressure ulcers acquired after admission/presentation to a healthcare setting
- G.** Artificial insemination with the wrong donor sperm or wrong egg
- H.** Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
- I.** Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

Examples of Sentinel Events

Care Management Events

- “Occurrences in which a patient dies or suffers serious injury as a result of failure to administer a prescribed medication (NQF, 2011: A-9).”
- “Occurrences in which a patient dies or suffers injury as a result of wrong administration technique (NQF, 2011: A-6).”
- “Occurrences in which a patient is administered an over- or under-dose of a medication including insulin, heparin, and any other high alert medication including but not limited to medications listed on the Institute for Safe Medication practices “High Alert Medication List” (NQF, 2011: A-9).”

Environmental Events

- A.** Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
- B.** Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
- C.** Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
- D.** Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

Examples of Sentinel Events

Environmental Events

- “Patient death or injury associated with unintended electric shock during the course of care or treatment (NQF, 2011: A-13).”
- “Staff death or injury associated with unintended electric shock while carrying out duties directly associated with a patient care process, including preparing for care delivery (NQF, 2011: A-13).”
- “Instances where physical restraints are implicated in the death e.g., lead to strangulation/entrapment, etc. (NQF, 2011: A-14).”

Radiologic Events

Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

Examples of Sentinel Events

Radiologic Events

- “Retained foreign object (NQF, 2011: A-15).”
- “External projectiles (NQF, 2011: A-15).”
- “Pacemakers (NQF, 2011: A-15).”

Potential Criminal Events

- A.** Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- B.** Abduction of a patient/resident of any age
- C.** Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
- D.** Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

Examples of Sentinel Events

Potential Criminal Events

- “Those without licensure to provide care given (NQF, 2011: A-16).”
- “Those with licensure who represent themselves and act beyond the scope of their licensure (NQF, 2011: A-16).”
- “Removal of a patient/resident, who does not have decision making capacity, without specific notification and approval by staff even when the person is otherwise authorized to be away from the setting (NQF, 2011: A-16).”

The importance of the completion of the Sentinel Event Forms

- The Sentinel Event Forms are updated and reformatted with every refinement in the NRS that occurs. The appropriate form must be used in conjunction with the date of the Sentinel Event.
- When completing a form, all required fields should be populated before submission of the form. This allows for the Division to enter the information into the database on a consistent basis with a higher accuracy rate at the time in which the yearly Summary Reports are submitted for review by the Board of Health.

Lessons Learned/Additional Information/Comments on Forms

- These sections are available for any notes or information that the facility may want to include in regards to the event that took place. These spaces are considered “optional.”

What is the date of a Sentinel Event?

- The date of event is the date when:
 - The event occurred.
 - A staff member can best place the patient exposure or incident in time.
- The date the facility became aware of an event is the date when:
 - A member of the facility staff learned of the event.

Mandatory Reporting of Sentinel Events: Reporting Timeline

After becoming aware of a sentinel event occurring at a facility:

- **0-24 hrs.** An employee must report a sentinel event to the Patient Safety Officer.
- **0-7 days.** The Patient Safety Officer must notify the patient that they were involved in a Sentinel Event.
- **0-14 days.** A Patient Safety Officer must report event to the DPBH.
 - **0-24 hrs.** An employee must report a sentinel event to the Patient Safety Officer.
 - **0-13 days.** A Patient Safety Officer must report event to the DPBH.
- **0-45 days.** The medical facility must conduct an investigation of the causes and/or contributing factors or both of the sentinel event.

Submission of the Sentinel Event forms in the mandated time frame by NRS

- Due to the nature of a Sentinel Event the mandated time frame is important to all parties involved.
- It indicates that the person(s) affected by the event were contacted in the required time mandated by NRS.
- It indicates that the facility at which the event occurred is aware of, reporting and researching the cause of the event.
- It allows the Division to keep a current and accurate, live database that reflects all events that occurred in the facilities.

Sentinel Event Contact Information

- Pursuant to [NRS 439.870](#), each medical facility required to report sentinel events must designate a Patient Safety Officer. This officer or employee of the facility has the responsibility to serve on the Patient Safety Committee ([NRS 439.875](#) and [NAC 439.920](#)), supervise the reporting of the sentinel events, take action as deemed necessary to ensure patient safety at the facility, and report any action taken to the Patient Safety Committee.

When a Contact Form must be completed

- A contact form must be completed when a new individual is designated as either a Patient Safety Officer or a Sentinel Event Reporter.

Completion of the Contact Form

- The completion of this form allows the Division to add the event into the data base with the correct reporter information. Additionally, if there are any questions about the reporting of the event(s), the updated information allows the Division to contact the individual that completed the form directly if necessary.

Completion of the Part I & Part II Forms

- [NRS 439.835](#) and [NAC 439.917](#) Mandates the reporting of a Sentinel Event in detail to the Nevada Division of Public and Behavioral Health.
- The completion of the Part I and Part II forms allows for the annual statistical reports to be as accurate as possible.
- The completion of the Part I and Part II forms allows for the Division to adequately research individual events when necessary.

Changes made to Part I Form

- Current Part I Form

TYPE OF EVENT

HAI other - specify:

other - specify:

OUTCOME

RISK

- Part I Form available October 1, 2013

TYPE OF EVENT

Changes made to Part II Form

- Registry Number will no longer be for state use only.

REGISTRY NUMBER:	<input type="text"/>
DATE RECEIVED:	<input type="text"/>

- The facility information has been slightly reformatted.

FACILITY INFORMATION

FACILITY LICENSE NUMBER:	<input type="text"/>		
FACILITY NAME:	<input type="text"/>		
REPORT COMPLETED BY:	<input type="text"/>	<input type="text"/>	<input type="text"/>
	LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE AND TIME FACILITY COMPLETED SECTION II:	<input type="text"/>		
	YYYYMMDD		

Citations

- National Quality Forum (NQF), *Serious Reportable Events in Health-care-2011 Update: A Consensus Report*, Washington, DC: NQF; 2011.
- Kvam, Jay. *Pre-and Post-AB28 Era in Nevada [Unpublished Newsletter]*. Carson City, Nevada. July 2013.
- Nevada State Legislature. Assembly Bill 28. 2013 77th Regular Session. Available at:
nelis.leg.state.nv.us/77th2013/App#/77th2013/Bill/Overview/AB28/

Thank you

If you have any questions or comments, please do not hesitate to contact the Sentinel Event Registry by telephone or email using the contact information listed below.



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