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2017 Sentinel Events Summary Report

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State Board Of Health Meeting

June 8, 2018

Department of Health and Human Services
Office of Analytics
And
Division of Public and Behavioral Health
Office of Public Health Informatics and Epidemiology
Sentinel Event Registry

Agenda

- Sentinel event definition (A ‘never’ event)
- Who should report sentinel events?
- Data collection methods
- Data analysis results
- Plans and Goals
- Conclusion

Definition

- Assembly Bill (AB28), effective 10/1/2013
- Defined as a serious reportable event included in Appendix A of "Serious Reportable Events in Healthcare—2011 Update: A Consensus Report."
- *- serious, largely preventable, and harmful clinical events that should 'never' happen -*
- Published by the National Quality Forum (NRS 439.830) .
- *Updated in 2013 to exclude healthcare acquired infections, HAI, reporting. All data included in this report has qualified per the definition of sentinel event in effect for 2017)*
- *(reporting has been conducted in Nevada since 2000, with force of statute since 2011)*

Who Should Report?

- **NRS 439.805 "Medical facility" defined.**

1. A hospital, as that term is defined in NRS 449.012 and 449.0151;

2. An obstetric center, as that term is defined in NRS 449.0151 and 449.0155;

3. A surgical center for ambulatory patients, as that term is defined in NRS 449.0151 and 449.019; and

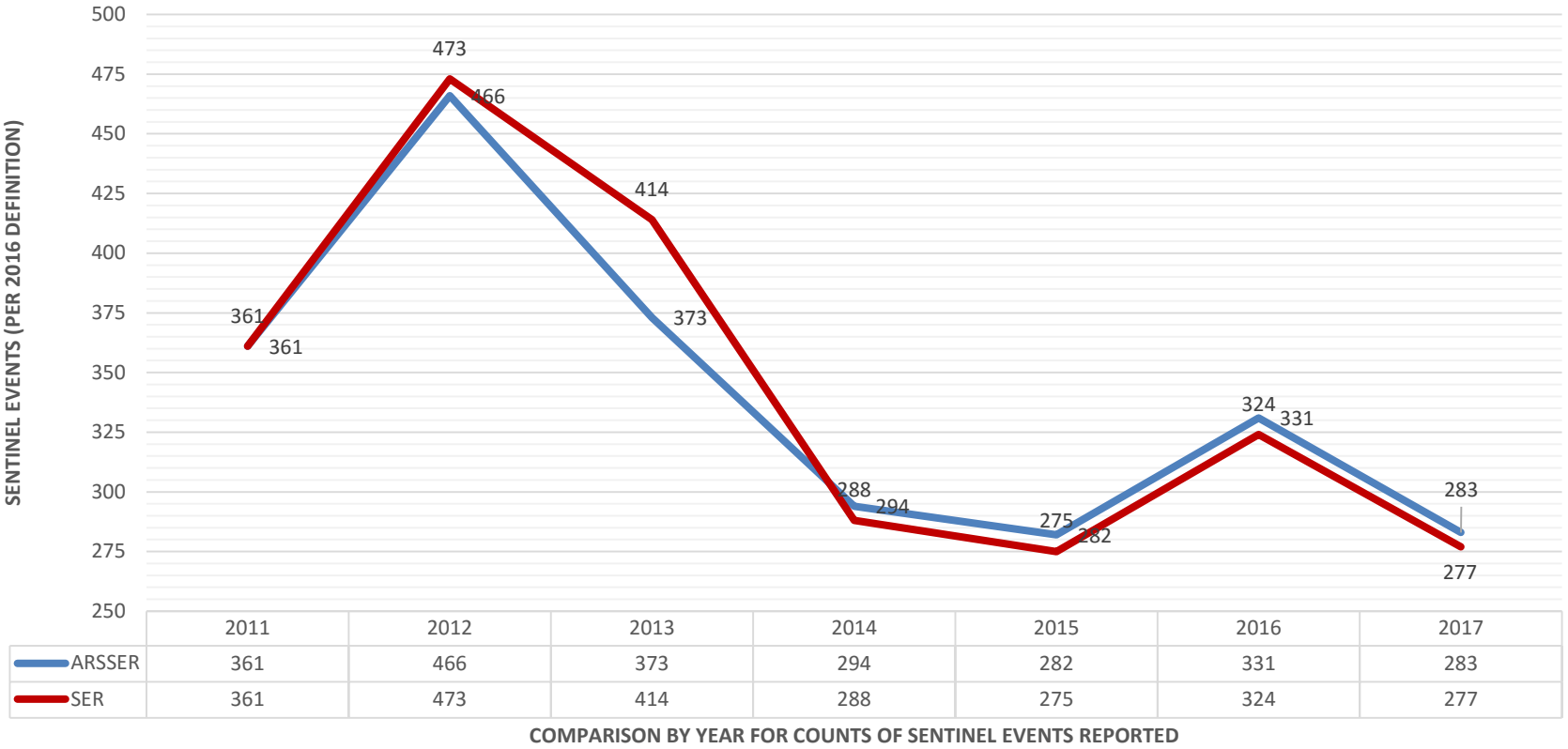
4. An independent center for emergency medical care, as that term is defined in NRS 449.013 and 449.0151.

Data Collection Methods

- Event Report forms:
  - Part 1 Initial report to sentinel events registry and
  - Part 2 Root Cause Analysis results
- Summary Annual Report forms: Sentinel event report summary form and patient safety committee form were due on March 1, 2017. (All reporting facilities required to file)

Sentinel Events Reporting Comparison

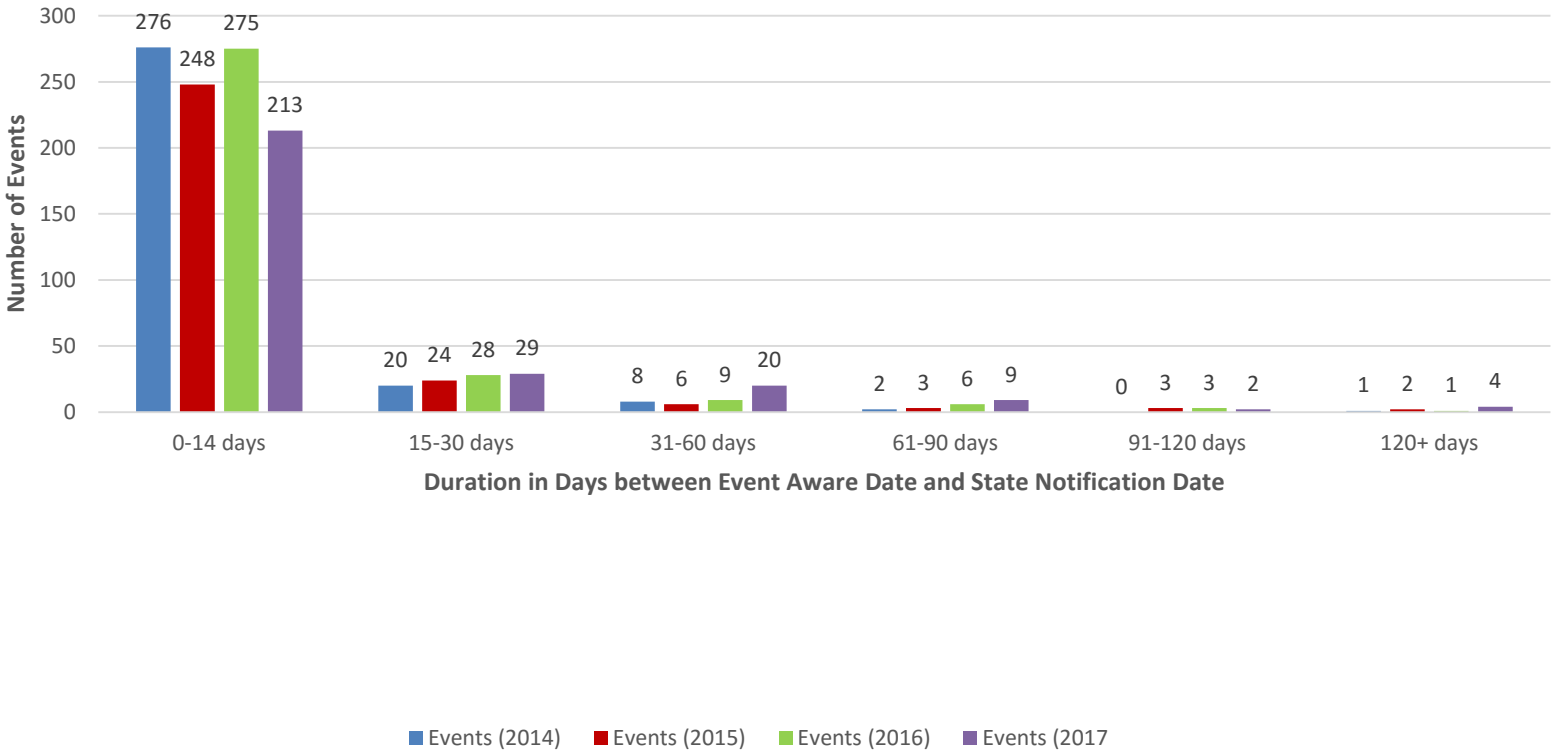
Comparison SER vs Annual Summary Report



	2011	2012	2013	2014	2015	2016	2017
ARSSER	361	466	373	294	282	331	283
SER	361	473	414	288	275	324	277

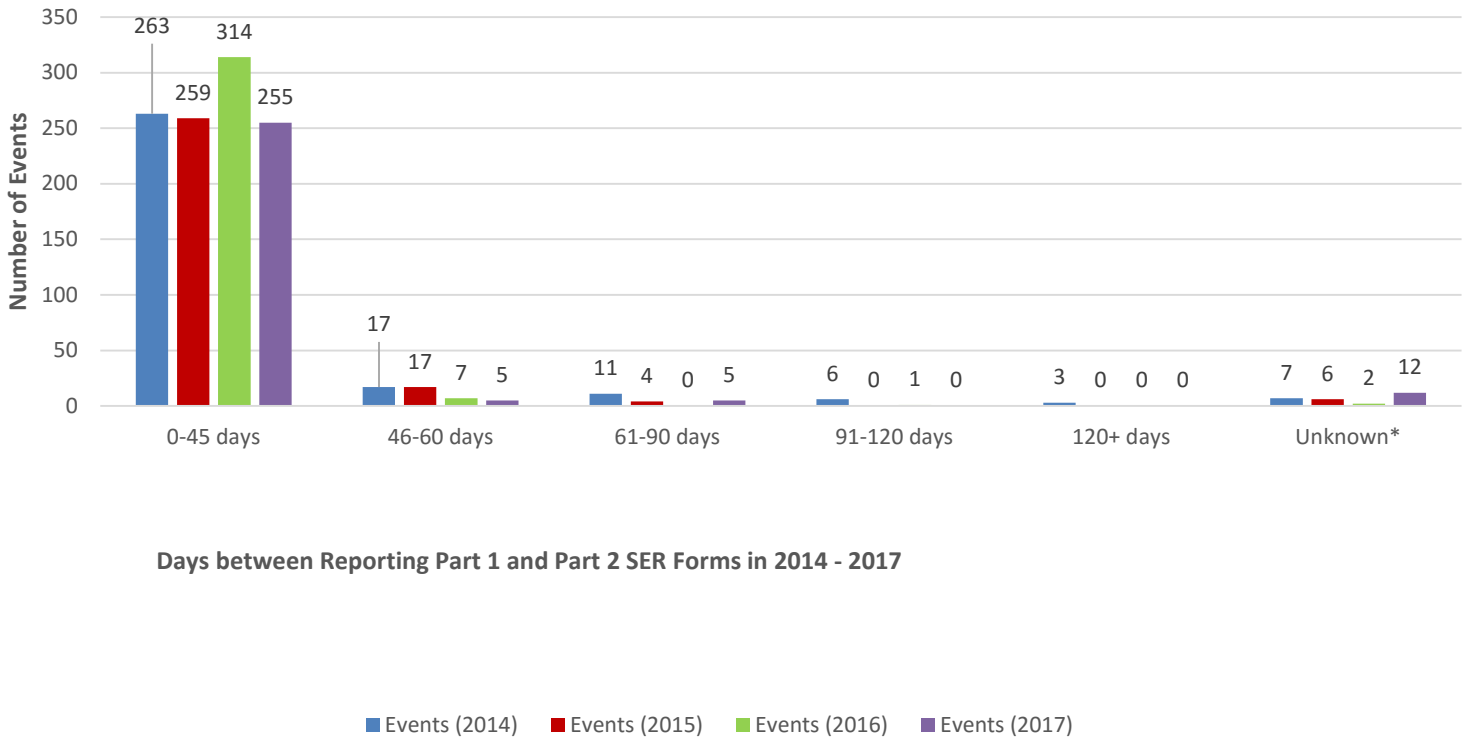
COMPARISON BY YEAR FOR COUNTS OF SENTINEL EVENTS REPORTED

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



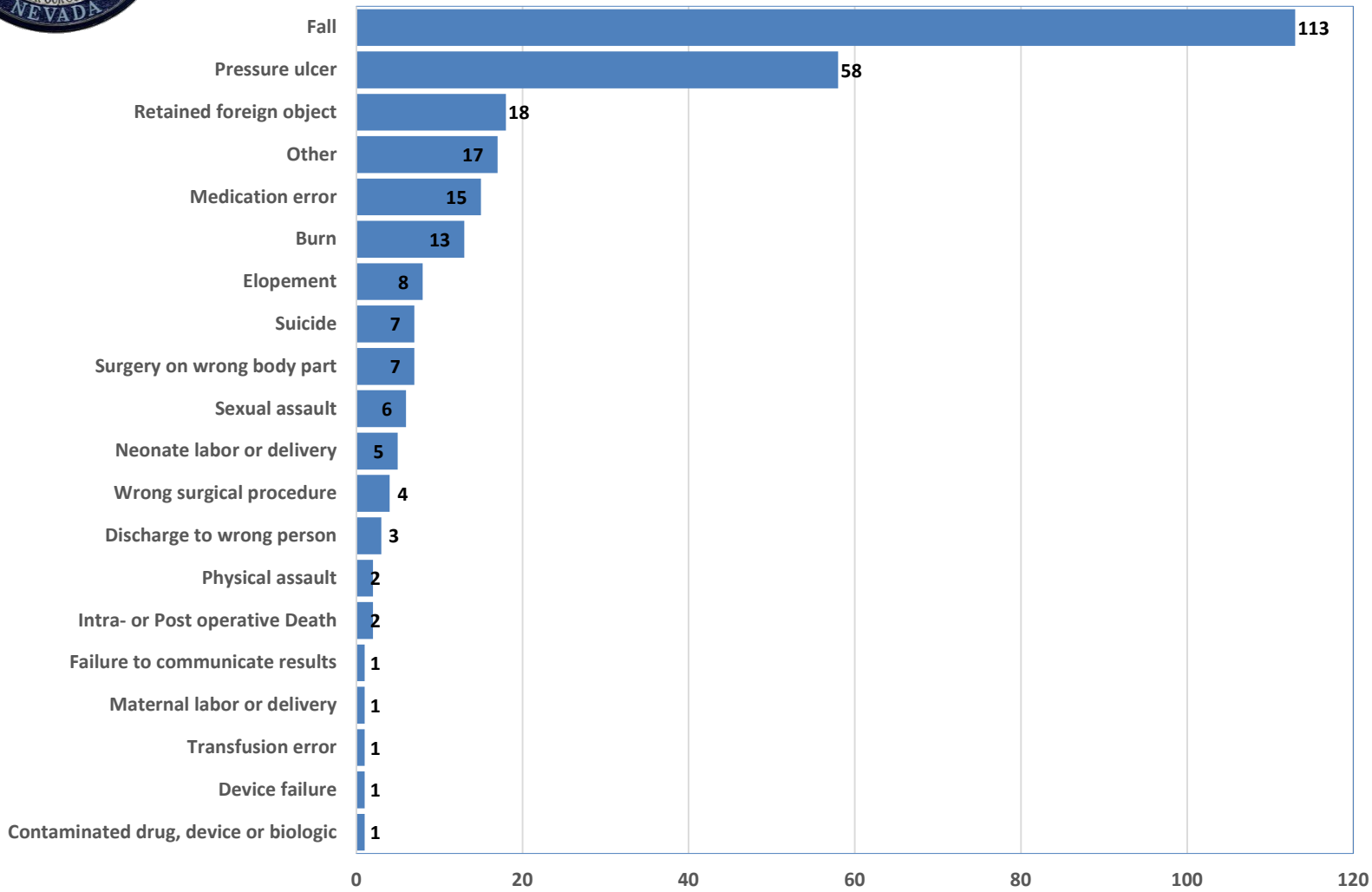
* This is the Form 1 Report.

Days Between Event Notification and Analysis Report Completion *



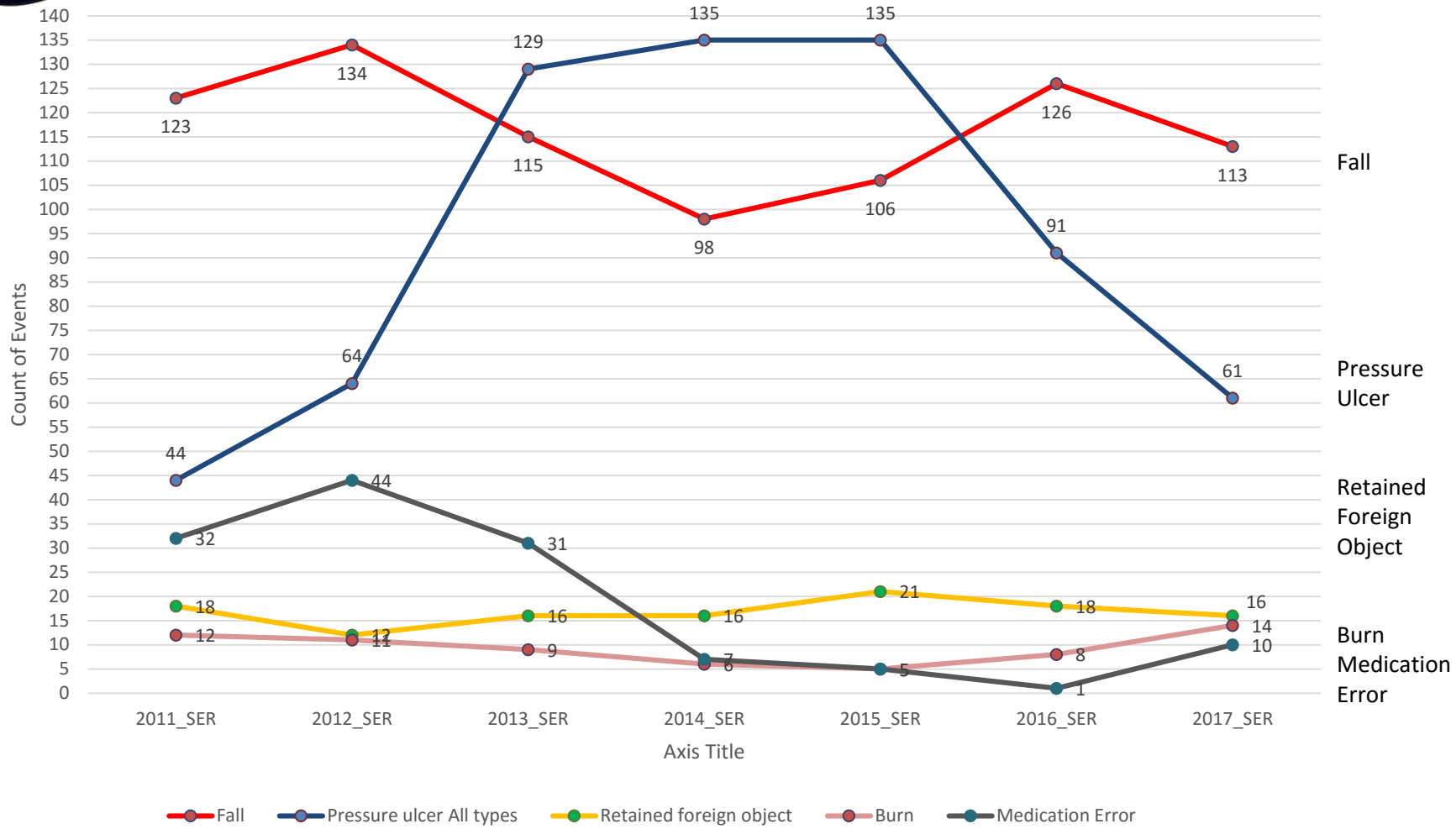
* This is from Form 1 Report to Form 2 Report.

Sentinel Events by Type in 2017

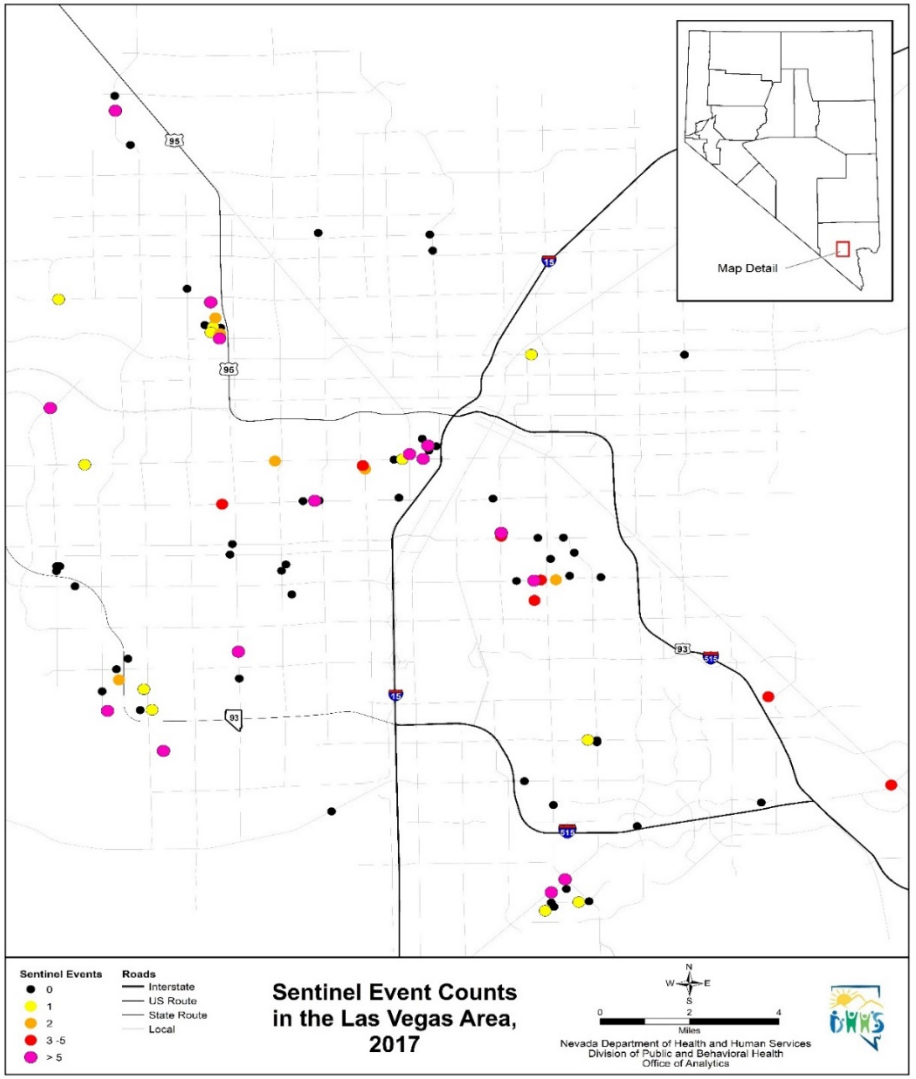


(from Annual Summary Report Form)

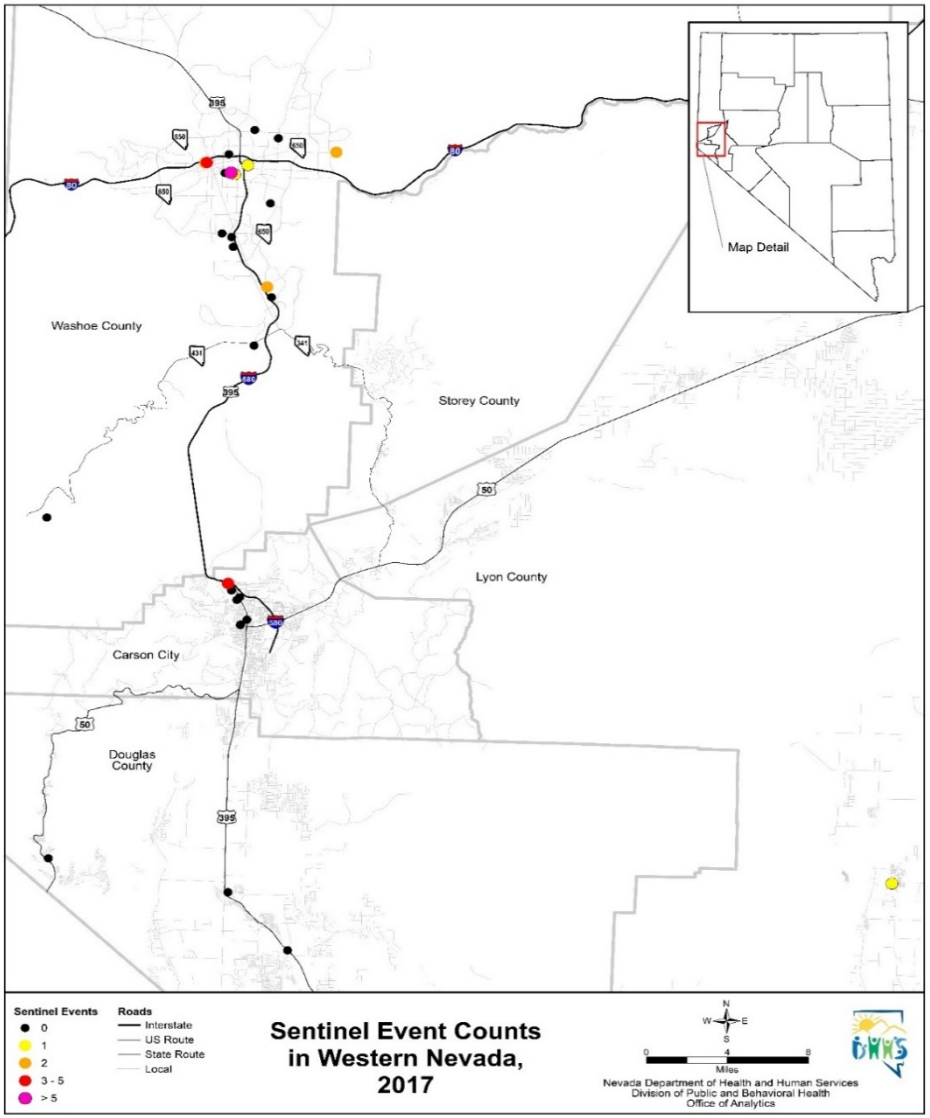
Top 5 Types of Sentinel



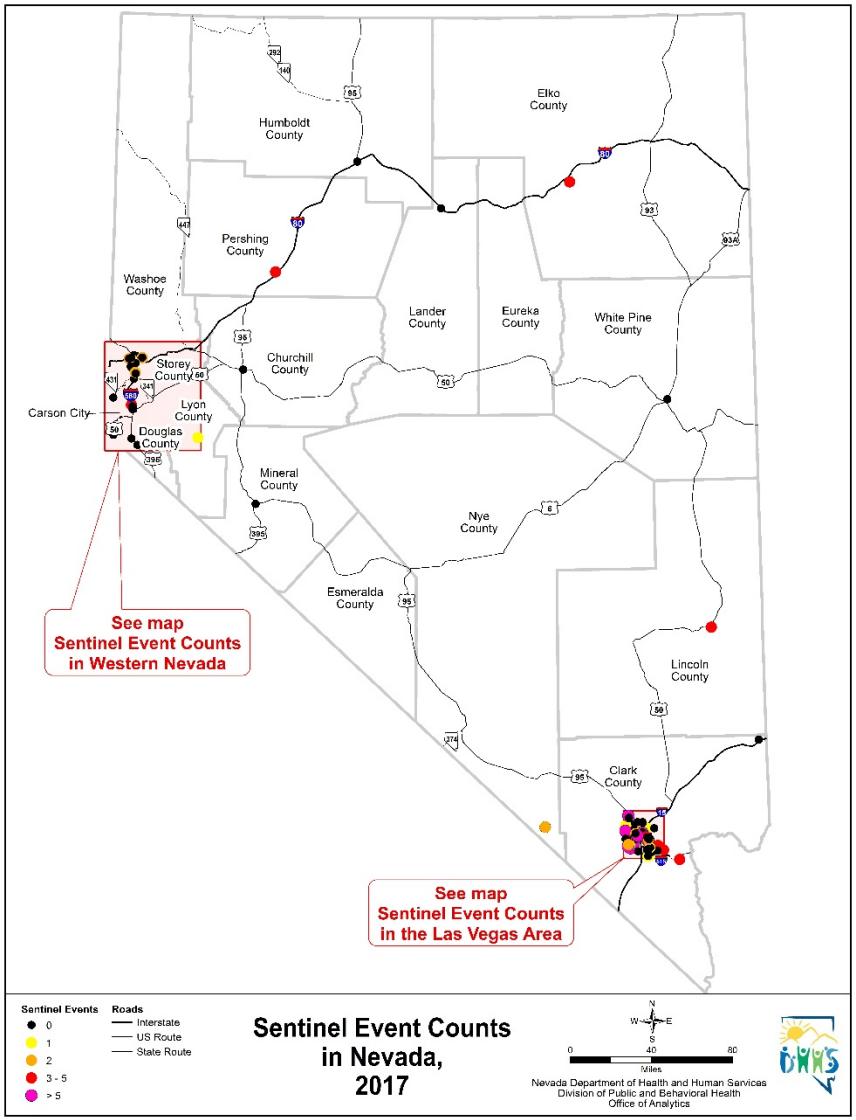
Sentinel Events By Location 2017



Sentinel Events By Location 2017



Sentinel Events By Location 2017



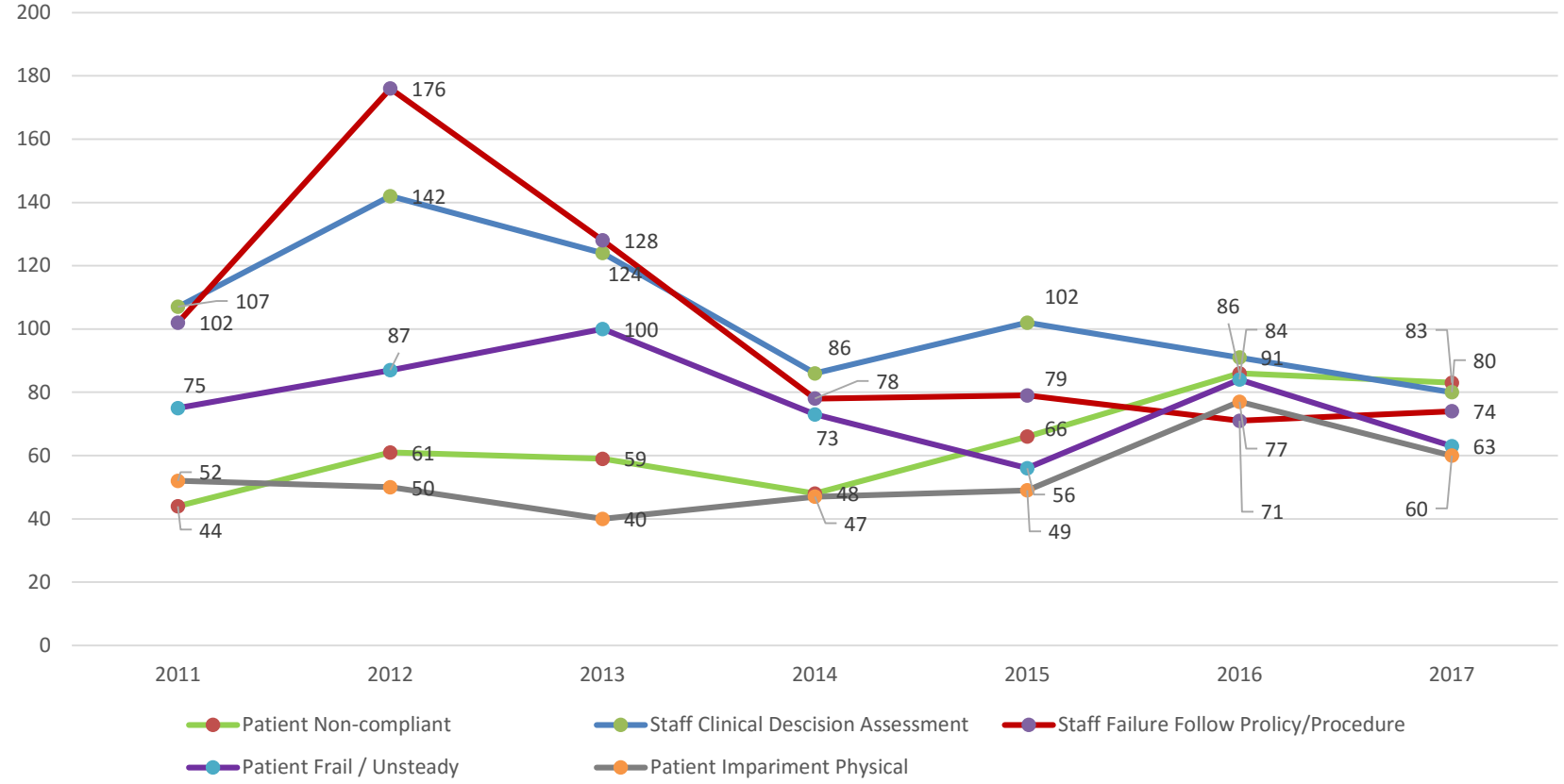
The 'where' of Sentinel Events Occurrence in 2017

(up to 4 can be selected)

Department/Location	Count	Percent		Department/Location	Count	Percent
Medical/surgical	88	29.8 %		Outpatient/ambulatory care	4	1.4 %
Intensive/critical care	29	9.8 %		Neonatal unit (level 2)	2	0.7 %
Intermediate care	20	6.8 %		Neonatal unit (level 3)	2	0.7 %
Emergency department	19	6.4 %		Observational/clinical decision unit	2	0.7 %
Inpatient rehabilitation unit	19	6.4 %		Pharmacy	2	0.7 %
Outpatient/ambulatory surgery	18	6.1 %		Antepartum	1	0.3 %
Psychiatry/behavioral health/geropsychiatry	15	5.1 %		Dialysis unit	1	0.3 %
Inpatient surgery	14	4.7 %		Endoscopy	1	0.3 %
Anesthesia/PACU	10	3.4 %		Laboratory	1	0.3 %
Imaging	10	3.4 %		Pediatric emergency department	1	0.3 %
Ancillary other	9	3.1 %		Pediatric intensive/critical care	1	0.3 %
Nursing/skilled nursing	8	2.7 %		Pediatrics	1	0.3 %
Labor/delivery	6	2 %		Pulmonary/respiratory	1	0.3 %
Cardiac catheterization suite	5	1.7 %		Trauma emergency department (level 1)	1	0.3 %
Long term care	4	1.4 %		**Total**	**295**	**100.00%**

Top Five Detailed Primary Contributing Factors in 2011-2017

674 detailed primary factors that contributed to 277 Sentinel Events in 2017, averaging 2.4 factors per event.

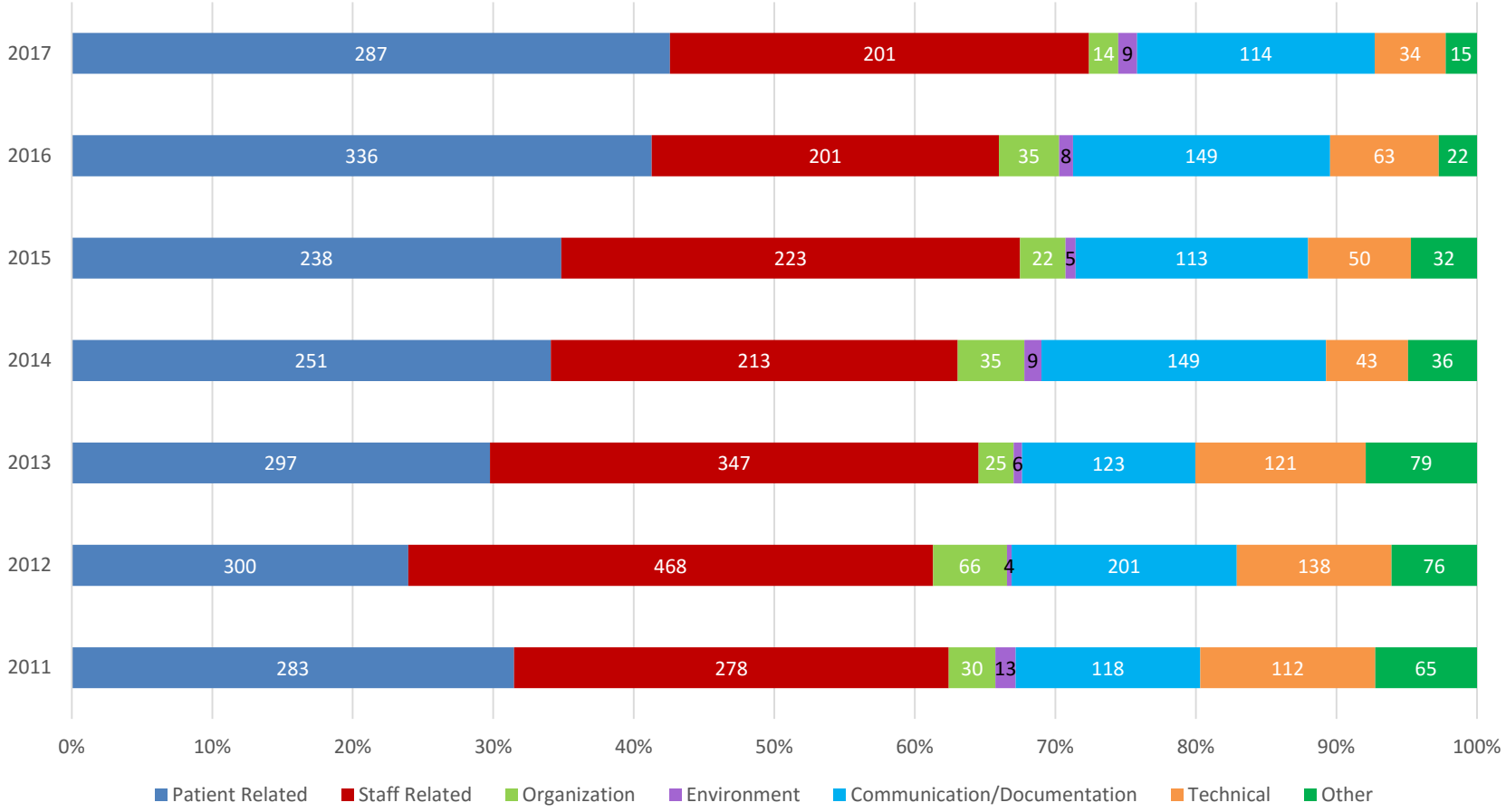


Detailed Primary Factors in 2016

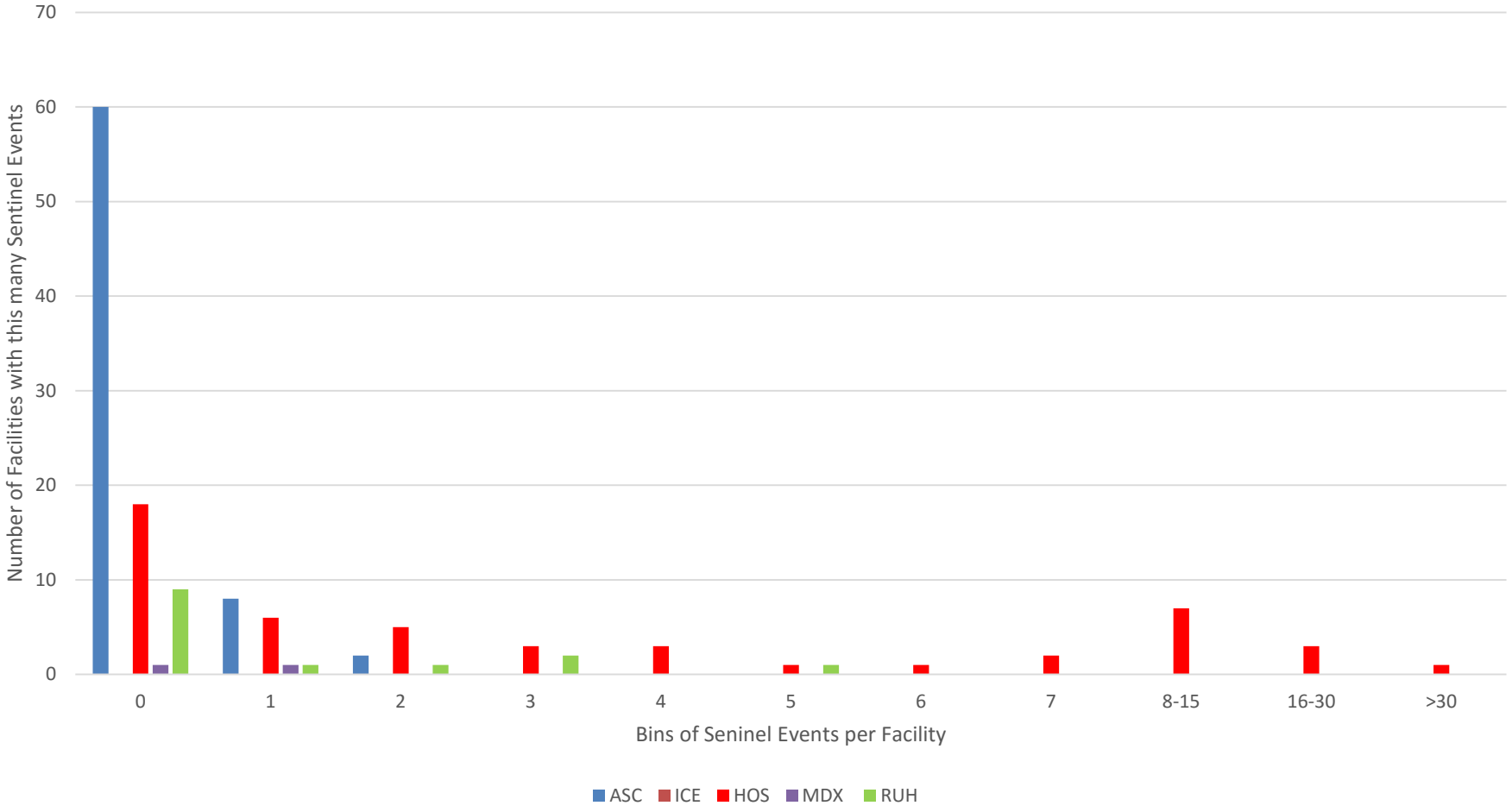
Factors (up to 4 per event can be selected)	2017 Count	2017 percent (%)
Patient Related Non-compliant	83	12.31
Staff-Related Clinical decision/assessment	80	11.87
Staff-Related Failure to follow policy and/or procedure	74	10.98
Patient-Related Frail/unsteady	63	9.35
Patient-Related Physical Impairment	60	8.9
Patient-Related Confusion	40	5.93
Staff-Related Clinical performance/administration	38	5.64
Communication/Documentation Hand off/teamwork/cross coverage	31	4.6
Communication/Documentation Lack of communication	28	4.15
Communication/Documentation Verbal communication inadequate	28	4.15
Communication/Documentation Lack of/inadequate documentation	19	2.82
Patient-Related Medicated	15	2.23
Other	15	2.23
Patient-Related Psychosis	10	1.48
Technical Equipment failure(s)	8	1.19
Technical Other	8	1.19
Patient-Related Self harm	7	1.04
Patient-Related Alcohol/drugs	6	0.89
Organization Inappropriate/no policy/process	5	0.74
Organization Training inadequate/not done	5	0.74
Technical Equipment incorrect	5	0.74
Staff-Related Iatrogenic error(s)	4	0.59
Environment emergency situation internal	4	0.59
Environment Wet/slippery floor/surface	4	0.59
All Others	29	4.3
Total	674	100

Contributing Factor Areas

Relative Comparison 2011 to 2017



Frequencies by Facility Type in 2017



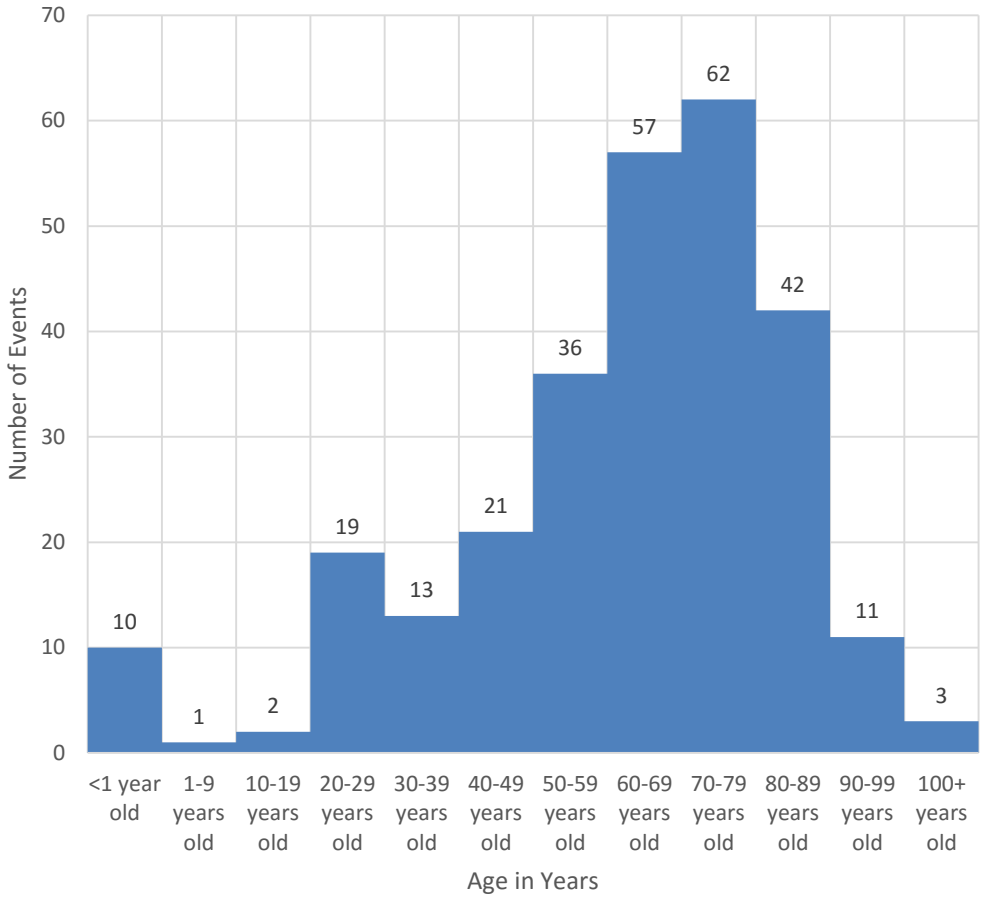
Patient Safety Committees 2017

Facilities Having 25 or More Employees and Contractors				Facilities Having Fewer Than 25 Employees and Contractors			
Monthly Meetings	Total Facilities	Percentage		Quarterly Meetings	Total Facilities	Percentage	
		2017	2016			2017	2016
Yes	82	89.13%	89.61%	Yes	45	97.83%	95.24%
No	8	8.70%	5.19%	No	1	2.17%	2.38%
Did Not Report	2	2.17%	5.19%	Did Not Report	0	0%	2.38%
Total	**92**	**100.00%**	**100.00%**	**Total**	**46**	**100.00%**	**100.00%**

Facilities Having 25 or More Employees and Contractors				Facilities Having Fewer Than 25 Employees and Contractors			
Mandatory Staff	Total Facilities	Percentage		Mandatory Staff	Total Facilities	Percentage	
		2017	2016			2017	2016
Yes	86	94.48%	84.42%	Yes	44	95.65%	77.08%
No	3	3.26%	5.19%	No	2	4.35%	10.42%
Did Not Report	3	3.26%	10.39%	Did Not Report	0	0%	2.08%
Total	**92**	**100.00%**	**100.00%**	**Total**	**46**	**100.00%**	**100.00%**

Sentinel Events by Age

Patient's Age	Count	Percent
<1 year old	10	3.6%
1-9 years old	1	0.4%
10-19 years old	2	0.7%
20-29 years old	19	6.9%
30-39 years old	13	4.7%
40-49 years old	21	7.6%
50-59 years old	36	12.9%
60-69 years old	57	20.5%
70-79 years old	62	22.3%
80-89 years old	42	15.1%
90-99 years old	11	4.00%
100+ years old	3	1.1%
Total (excludes missing DOB)	**277**	**100.00%**



REDCaps
(Research Electronic Data Capture Application)

- Web based data input went live Oct. 20, 2016
- Mostly Positive Implementation
- Wide range of Reporter skills and experience
- Application Best-Practice Provided 1-to-1
- Sentinel Event Toolkit – not fully utilized
- Planned Training, and User Interface Reviews

Plans and Goals

- Provide technical assistance and develop improvements to the REDCap Database Reporting System
- Prepare Reporter Training Videos
- Review Stakeholder Program Knowledge
- Review Implementation of the Sentinel Events Statues and Administrative Code
- Sentinel Event Related Educational Activities

Conclusion

- The majority of the facilities followed the procedures and requirements to submit the specific-event and annual summary reports.
- Most had internal patient safety plans.
- There appears to be a genuine earnestness to comply, report on and seek improvement from the reporting healthcare facilities.

Reference

- **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 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/

Thank you!
From the Team

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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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