2013 ANNUAL
SENTINEL EVENT SUMMARY REPORT

Department of Health and Human Services
Division of Public and Behavioral Health
Office of Public Health Informatics and Epidemiology

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PURPOSE

Legislation passed during the 2009 Legislative Session requires the Division of Public and Behavioral Health (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 legislators and the public concerning summary and individual reports submitted by facilities to the Sentinel Event Registry. This is the fifth annual summary report to be compiled pursuant to Nevada Revised Statutes (NRS) 439.843.

SENTINEL EVENT DEFINED

During 2013, 2 sentinel event definitions were in effect for portions of the year. From January 1, 2013 through September 30, 2013, a sentinel event was defined 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 (AB 59)."

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)". This report covers the usage of both definitions of a sentinel event as defined by Assembly Bills 59 and 28 during 2013.

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 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

On January 13, 2014, each medical facility was sent a sentinel event report summary form to be completed and returned to DPBH by March 1, 2014, 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.

DPBH sent the form to 123 mandatory sentinel event reporting medical facilities. These medical facilities included 61 hospitals, 61 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 1 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

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 2013.

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 2013, the medical facilities indicated that they had reported a total of 1,268 sentinel events.

Table 1 – sentinel event type totals from the 2013 sentinel event report summary forms

event type	total	percentage
abduction	**0**	**0.0%**
air embolism	**2**	**0.2%**
burn	**5**	**0.4%**
catheter-associated urinary tract infection (CAUTI)	**241**	**19.0%**
central line-associated bloodstream infection (CLABSI)	**176**	**13.9%**
contaminated drug, device, or biologics	**3**	**0.2%**
device failure	**2**	**0.2%**
discharge to wrong person	**0**	**0.0%**
electric shock	**0**	**0.0%**
elopement	**12**	**0.9%**
failure to communicate test result	**2**	**0.2%**
fall	**109**	**8.6%**
healthcare-associated infection (HAI) – other	**277**	**21.8%**
impersonation of healthcare provider	**0**	**0.0%**
intra- or post-operative death	**10**	**0.8%**
introduction of metallic object into magnetic resonance imaging (MRI) area	**1**	**0.1%**
lost specimen	**1**	**0.1%**
maternal labor and delivery	**0**	**0.0%**
medication error	**29**	**2.3%**
neonate labor and delivery	**5**	**0.4%**
physical assault	**4**	**0.3%**
pressure ulcer	**72**	**5.7%**
restraint	**1**	**0.1%**
retained foreign object	**13**	**1.0%**
sexual assault	**7**	**0.6%**
surgical site infection (SSI)	**192**	**15.1%**
suicide	**5**	**0.4%**
surgery on wrong body part	**3**	**0.2%**
surgery on wrong patient	**2**	**0.2%**
transfusion error	**2**	**0.2%**
ventilator-associated pneumonia (VAP)	**6**	**0.5%**
wrong or contaminated gas	**0**	**0.0%**
wrong sperm or egg	**0**	**0.0%**
wrong surgical procedure	**1**	**0.1%**
other	**85**	**6.7%**
total	**1,268**	**100%**

A total of 85 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**
abdominal pain	**2**
adverse drug reaction	**1**
allegation of abuse	**1**
bowel perforation	**1**
contamination of sterile location	**1**
death from self-administered heroin	**1**
death, after discharge	**1**
death, delayed treatment in the emergency department	**1**
death, unexpected, not otherwise classified	**5**
deep vein thrombosis	**20**
delay in treatment	**8**
exsanguination secondary to spinal surgery	**1**
hospital acquired injury	**3**
invasive procedure on wrong organ	**1**
intravenous site tissue necrosis	**1**
misread test	**1**
monitor lead detachment	**1**
near miss for wrong site surgery	**1**
post-operative injury	**1**
post-operative pneumonia	**1**
post-operative wound infections	**2**
post-operative hemorrhage	**1**
procedural complication	**17**
pulmonary embolism	**1**
suicide attempt	**4**
supraventricular tachycardia noted on electrocardiogram	**1**
treatment care management	**3**
wrong implant	**1**
wrong side chest tube	**1**
wrong site anesthetic procedure	**1**
total	**85**

A total of 277 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**
asymptomatic bacteremic urinary tract infection	**2**
ACN (uncertain meaning of acronym used)	**5**
blood culture	**1**
bloodstream infection	**21**
bronchitis	**1**
peripherally inserted central catheter	**1**
Clostridium difficile	**127**
E Coli/Klebsiella	**1**
gastroenteritis	**7**
gastrointestinal with secondary bloodstream infection	**3**
hospital-acquired pneumonia	**1**
infection related ventilator associated complication	**5**
methicillin resistant *Staphylococcus aureus*	**40**
osteomylitis	**1**
peritonitis sp. *paracentesis*	**2**
pneumonia	**6**
pneumonia with secondary bloodstream infection	**2**
reproductive tract	**1**
respiratory sputum	**1**
skin infection	**1**
skin/soft tissue with secondary bloodstream infection	**1**
urinary tract infection, non-catheter-related	**26**
urinary tract infection with secondary bloodstream infection	**2**
vancomycin-resistant *Enterococci (VRE)*	**13**
ventilator-associated complication	**6**
total	**277**

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 892 of the total sentinel events reported. Of these, HAI-other was predominant at 277 reports; CAUTIs followed with 241 reports. Falls were the second most common at 109, and 'other' sentinel events were third at 85. Overall, HAIs amount to just over two-thirds (70.3%) 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 2013 sentinel event report summary form. As was the case in 2009, 2010, 2011, and 2012, 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, 79 facilities indicated that they had 25 or more employees, and 43 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 114 of the 122 facilities (93.4%) met as frequently as required. Among the facilities that had 25 or more employees, 74 (93.7%) of the patient safety committees met on a monthly basis. Among the facilities that had fewer than 25, 40 (93.0%) 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	**74**	**93.7%**
no	**5**	**6.3%**
total	**79**	**100%**

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

quarterly	total	percentage
yes	**40**	**93.0%**
no	**3**	**7.0%**
total	**43**	**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 121 of the 122 facilities (99.2%) had the appropriate staff in attendance at the patient safety committee meetings. Among the facilities that had 25 or more employees, 100.0% had the appropriate staff in attendance. Among the facilities that had fewer than 25, 97.7% had the appropriate staff in attendance. For the 1 that did not, the facility was missing a doctor and a CEO or CFO.

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

monthly	total	percentage
yes	**79**	**100.0%**
no	**0**	**0.0%**
total	**79**	**100%**

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

quarterly	total	percentage
yes	**42**	**97.7 %**
no	**1**	**2.3%**
total	**43**	**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 2013.

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 2013, a total of 1,268 sentinel events were indicated as reported according to the summary forms versus 1,352 as recorded in the Sentinel Events Registry, 14 of which were determined not to be sentinel events, bringing the actual total to 1,338.

Table 8 – sentinel event type totals from the 2013 sentinel event report summary forms and Sentinel Events Registry

event type	summary	registry
abduction	0	1
air embolism	2	0
burn	5	6
CAUTI	241	244
CLABSI	176	168
contaminated drug, device, or biologics	3	2
device failure	2	3
discharge to wrong person	0	0
electric shock	0	0
elopement	12	11
failure to communicate test result	2	0
fall	109	115
HAI – other	277	315
impersonation of healthcare provider	0	0
intra- or post-operative death	10	10
introduction of metallic object into MRI area	1	0
lost specimen	1	1
maternal labor and delivery	0	1
medication error	29	31
neonate labor and delivery	5	4
physical assault	4	5
pressure ulcer	72	57
restraint	1	1
retained foreign object	13	16
sexual assault	4	8
SSI	192	183
suicide	5	5

event type	summary	registry
surgery on wrong body part	3	4
surgery on wrong patient	2	1
transfusion error	2	3
VAP	6	5
wrong or contaminated gas	0	0
wrong sperm or egg	0	0
wrong surgical procedure	1	0
other	85	138
total	**1,268**	**1,352**

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:
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

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:
http://www.qualityforum.org/projects/hacs_and_sres.aspx

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

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ADDITIONAL INFORMATION

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