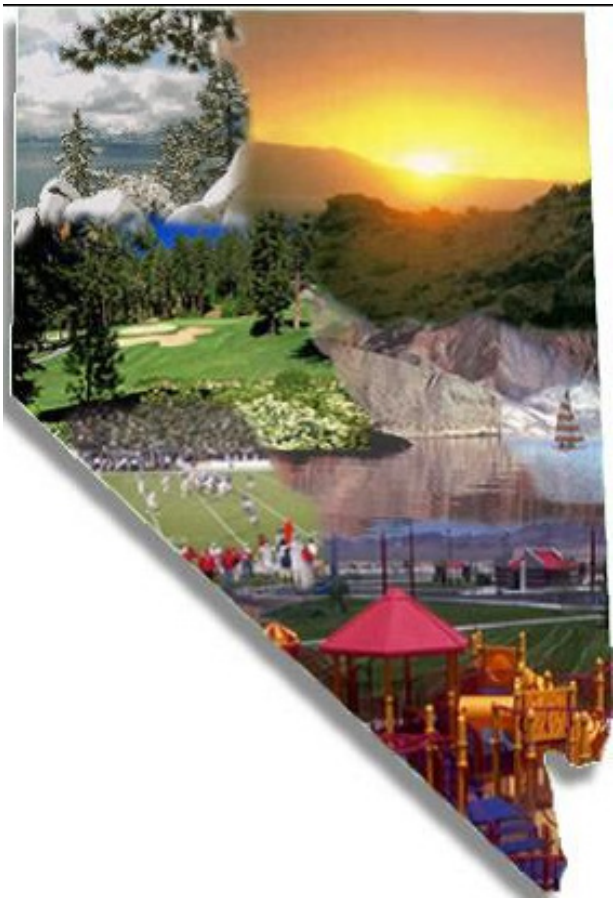

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2019 Annual Sentinel Event Summary Report

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Sentinel Event Report Organization and Contents

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Acknowledgments

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The Office of Analytics and OPHIE acknowledge all the agencies and health care facilities for their ongoing contribution to the Sentinel Event program and the peer review panel(s) for their advice and recommendations to this report. This report serves as a testimony to the patients and their families who have experienced adverse outcomes and the consequences of clinical errors, and a spotlight upon their plight. Without all concerned parties support, cooperation, and dedication to improve patient safety in Nevada this report would not be possible.

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Background and Purpose

During the 2009 session, the Nevada Legislature passed a law requiring DPBH to compile the Annual Sentinel Event Report and submit the compilation to the State Board of Health by June 1 of each year. The purpose of this report is to share the outcomes, investigations, and root causes of sentinel events. It is intended for use by legislators, health care facilities, patients and their families, and the public. The contents contain results from both the annual summary report for the Sentinel Event Registry (ASRSER) and the individual reports submitted by facilities to the Sentinel Event Registry (SER). This is the tenth annual summary report compiled pursuant to Nevada Revised Statutes (NRS) **439.843**.

This report will provide a summary of sentinel events to the public, health care consumers, health care providers, health care organizations and regulators in Nevada from various perspectives and areas. This report aims to help readers see the trends from year to year, to identify areas that have improved and to shed light on areas that still need improvement.

The data in this report reflect a transparency in addressing patient safety issues in Nevada. A facility's size, type, volume of services, complexity of procedures, and staff's understanding of the definition of the sentinel event will influence the number of the events reported. It is expected that through this report health care consumers, health care providers and health care organizations will have some basis to achieve improved outcomes. Consumers can manage their health care decisions better; health care providers can learn from these events to prevent them from happening again (i.e. to develop and implement improved safety strategies); and organizations and regulators will have uniform and comparable data tools to assess accountability of health care facilities in Nevada.

Sentinel Event Defined

A sentinel event means an event included in Appendix A of "Serious Reportable Events in Healthcare--2011 Update: A Consensus Report," published by the National Quality Forum. If the publication described above is revised, "sentinel events" means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision (**NRS 439.830**). Use the following link for further details on Appendix A of "**Serious Reportable Events in Healthcare 2011".**

As described by the National Quality Forum, sentinel events are events in the following areas of health care: surgical or invasive events, product or device events, patient protection events, care management events, environmental events, radiologic events and potential criminal events. Another description used for sentinel events found in literature prior to legislative action classified these events as 'never events,' as in they should never happen: a set of serious, largely preventable, and harmful clinical events. The most current National Quality Forum definition of a sentinel event can be found here: **Quality Forum Topics SRE List**

In 2013, certain types of Healthcare Acquired Infections (HAI) that had been included in SER data reporting requirement were excluded from the sentinel event report as they no longer met the definition of a sentinel event. These infections are recorded in the *National Healthcare Safety Network (*NHSN) reporting system at the Centers for Disease Control and Prevention (CDC). All reporting for current and past years included in this report reflect only sentinel events as defined in 2019. In order to accommodate historic data and to allow for additional data for a research purpose, various health care acquired-infection-related reporting categories from the definition of a sentinel event prior to 2014 have been included in the new standardized event list as volunteer reporting.

The Sentinel Events Registry is a database used to collect, compile, 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 and work culture level.

NRS 439.835 requires that medical facilities report sentinel events to DPBH. The SER database is administered by OPHIE. As specified in **NRS 439.805**, the medical facility types required to report sentinel events are as follows:

The definition for medical facility for sentinel events is as follows:

NRS 439.805 "Medical facility" defined. "Medical facility" means:

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**.

(Added to NRS by **2002 Special Session, 13**)

Senate Bill (SB) 457

(https://www.leg.state.nv.us/App/NELIS/REL/80th2019/Bill/6853/Text) This bill was passed during Nevada's 80th Legislative Session (Spring 2019). This bill further defined the types of health facilities that must report sentinel events to the Division of Public and Behavioral Health (DPBH). The legislation amended NRS 439 (439.803) to expand the Sentinel Event Registry participation from "Medical facility," to, "Health facility" and added the reporting requirement of any non-natural death that occurs in the facility. Some aspects of SB457 are not a part of the Sentinel Events Registry.

NRS 439.803 requires that health facilities report sentinel events to DPBH. The SER database is administered by OPHIE. As specified in **NRS 439.803**, the health facility types required to report sentinel events are as follows:

The definition for health facility for sentinel events is as follows:

NRS 439.803 "Health facility" defined. "Health facility" means:

1. Any facility licensed by the Division pursuant to chapter 449 of NRS; and
2. A home operated by a provider of community-based living arrangement services, as defined in NRS 449.0026.

(Added to NRS by 2019, 1666)

Table 0: Health Care Facility List SB457 new for 2020

Facility Code	Facility Type Description
HHA	AGENCY TO PROVIDE NURSING IN THE HOME
HBR	AGENCY TO PROVIDE NURSING IN THE HOME - BRANCH OFFICE
HSB	AGENCY TO PROVIDE NURSING IN THE HOME - SUB UNIT
PCS	AGENCY TO PROVIDE PERSONAL CARE SERVICES IN THE HOME
BPR	BUSINESS THAT PROVIDES REFERRALS TO RFFG
CTC	COMMUNITY TRIAGE CENTER
HFS	FACILITY FOR HOSPICE CARE
ICF	FACILITY FOR INTERMEDIATE CARE
IMR	FACILITY FOR INTERMEDIATE CARE/IID
MDX	FACILITY FOR MODIFIED MEDICAL DETOXIFICATION
SNF	FACILITY FOR SKILLED NURSING
ADC	FACILITY FOR THE CARE OF ADULTS DURING THE DAY
ADA	FACILITY FOR THE TREATMENT OF ABUSE OF ALCOHOL OR DRUGS
ESRD	FACILITY FOR THE TREATMENT OF IRREVERSIBLE RENAL DISEASE
TLF	FACILITY FOR TRANSITIONAL LIVING OF RELEASED OFFENDERS
NTC	FACILITY FOR TREATMENT WITH NARCOTICS
HWH	HALF-WAY HOUSE FOR RECOVERING ALCOHOL AND DRUG ABUSERS
HIC	HOME FOR INDIVIDUAL RESIDENTIAL CARE
HPC	HOSPICE CARE - PROGRAM OF CARE
HOS	HOSPITAL
ICE	INDEPENDENT CENTER FOR EMERGENCY MEDICAL CARE
NSP	NURSING POOL
OPF	OUTPATIENT FACILITY
PCO	PERSONAL CARE AGENCY THAT IS ALSO ISO CERTIFIED
PRTF	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
AGC	RESIDENTIAL FACILITY FOR GROUPS
RHC	RURAL CLINIC
RUH	RURAL HOSPITAL
SFD	SKILLED NURSING FACILITY DISTINCT PART OF HOSPITAL
ASC	SURGICAL CENTER FOR AMBULATORY PATIENTS

SB457 notification was sent to the email on file with the Division of Public and Behavioral Health, Health Care Quality and Compliance license database (https://nvdpbh.aithent.com/login.aspx) informing 1513 facilities of the new NRS affecting their health care facility (including those already required). Subsequently one facility type that was not notified will be added to the follow up notification (23 health care facilities (1536)). Of the 1513 facilities, as of this report date, 441 have made an effort to comply. Follow up notification is scheduled as soon as possible within the context of the COVID-19 pandemic staff requirements.

NRS 439.830 "Sentinel event" defined.

1. (b) Any death that occurs in a health facility.

NRS 439.837 Mandatory investigation of sentinel event by health facility; exceptions.

1. Except as otherwise provided in subsections 2 and 3, a health facility shall, upon reporting a sentinel event pursuant to NRS 439.835, conduct an investigation or cause an investigation to be conducted concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.

2. A health facility is not required to take the actions described in subsection 1 concerning a death confirmed to have resulted from natural causes.

3. A residential facility for groups, home for individual residential care or facility for hospice care is not required to take the actions described in subsection 1 concerning a death that appears to have resulted from natural causes.

4. As used in this section:

(a) "Facility for hospice care" has the meaning ascribed to it in NRS 449.0033.

(b) "Home for individual residential care" has the meaning ascribed to it in NRS 449.0105.

(c) "Residential facility for groups" has the meaning ascribed to it in NRS 449.017.

(Added to NRS by 2009, 3068; A 2019, 1667)

REDCap (Research Electronic Data Capture Application) reporting forms were retooled to accommodate the SB457 program expansion. The REDCap reporting system now consists of three projects, SER457_EventReporting, SER457_AnnualReport, and SER457_Contacts. The ASRSER is a separate project now and does not include facility contact forms.

Standardizing the list of event types for both the event reporting and annual reporting options was undertaken. New event codes were assigned, with links to the appropriate NQF (National Quality Forum) reference. The new list is included as an appendix to the Frequently Asked Questions (FAQ). In addition, several voluntary reporting event codes were included for backward data compatibility, and for research purposes.

Methodology

Pursuant to **NRS 439.865, NRS 439.840(2), NRS 439.845(2)b, NRS 439.855** , and **NAC439.900-920,** each health 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. All forms are marked 'Unverified' by the reporting party upon completion and submittal. Once submitted to the sentinel event database, the SER Registrar will review the record and mark the form record as 'Verified.' 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 by the facility-designated patient safety officer (PSO), or by a facility-designated sentinel event reporter (allowing up to a total of three authorized reporters per facility). Implemented in 2016, a new reporting system utilizes the Research Electronic Capture (REDCap) web-based data input system (https://www.project-redcap.org/). As of October 20, 2016, this system can be located at **https://dpbhrdc.nv.gov/redcap/**. The Sentinel Event Registrar (a 20% FTE position) verifies the data entry content for qualified reporting individuals, validates the correct entry of required fields, and then notifies the facility of data requiring additional input, or a successful data entry effort can be verified by the record having a locked, 'Verified' status. With the staff requirements around the COVID-19 pandemic some data management has been delayed.

The Annual Summary Report for the sentinel event registry (ASRSER) form is available through the REDCap reporting system. Each medical facility was to complete the online reporting requirement by March 1, 2020, for the calendar year 2019. 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**.

Due to implementation of the SB457 and due to unforeseen circumstances surrounding the COVID-19 pandemic this year's deadline has not been strictly enforced, nor have reminders sent.

All values reported as percentages reflect rounding and may not add up to 100 percent.

All data reported reflects reporting during the calendar year.

Section II-a: Sentinel Event Summary Report Information

This section provides information regarding the total number of sentinel events indicated by the health facilities as reported to the SER throughout the year, as well as a breakdown of the event types.

Event Types and Totals

In 2019, 56 facilities reported sentinel events. Of those reporting, 50 were 2019 NRS required-reporting facilities. A total of 331 sentinel event records were reported, grouped as follows:

306 events were true sentinel events per the current definition.

23 events were voluntary reporting related to HAI, and other adverse but not NQF events.

2 events reported were later deemed to not be NQF sentinel events.

* Three events (3) from 2018, seven events (7) from prior years remain pending. Events pending determination are awaiting either an autopsy or laboratory testing results yet to be available to the state, or the review of the record by licensed medical professionals.

Table 1: Sentinel Event Record Classification 2019

Year of Record	Event Type	Count in 2019
2019	Not a Sentinel Event	2
2019	To be determined	0
2019	Is a Sentinel Event	306
2019	Voluntary reporting (HAI's, and other adverse but not NQF events)	23

Table 2: Sentinel Event Facility Types from Annual Reports 2019 (at least one event)

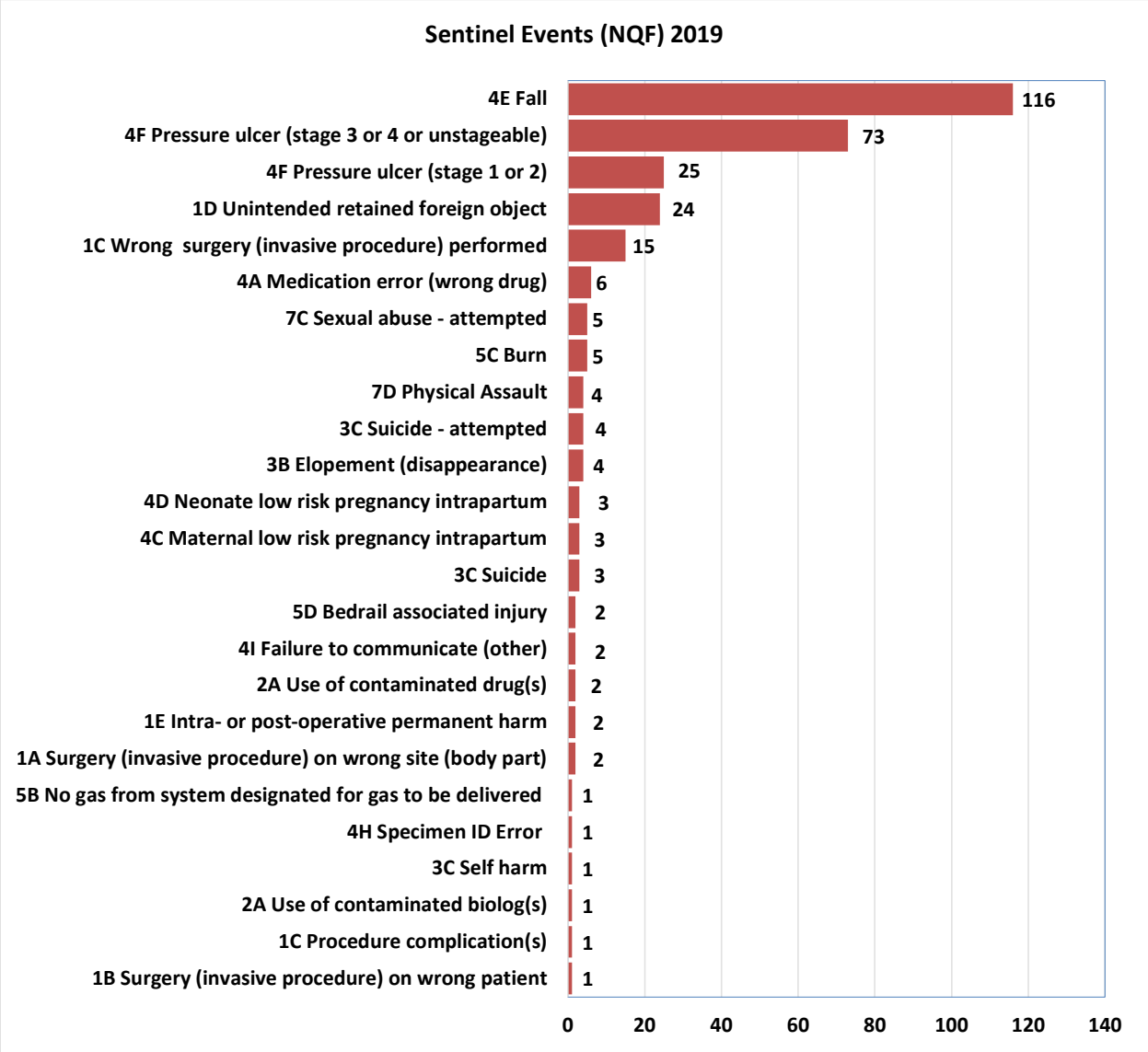
Facility Type Defined	Facility Type Code	Facility Count	Count of Facility Types in CY 2019	Count of sentinel events by Facility Type in 2019
Surgical center for ambulatory patients	ASC	74	9	10
Hospital	HOS	54	32	276
Rural hospital	RUH	14	9	20
Total		142	50	306

Table 3: Sentinel Event Type Totals in 2019 (from the sentinel events registry forms)

Rank	NQF – Event	Count	Percent	Sentinel Event
1	4E Fall	116	35	YES
2	4F Pressure ulcer (stage 3 or 4 or unstageable)	73	22.1	YES
3	4F Pressure ulcer (stage 1 or 2)	25	7.6	YES

3	1D Unintended retained foreign object	24	7.3	YES
4	1C Wrong surgery (invasive procedure) performed	15	4.5	YES
6	4A Medication error (wrong drug)	6	1.8	YES
7	7C Sexual abuse – attempted	5	1.5	YES
8	5C Burn	5	1.5	YES
9	3B Elopement (disappearance)	4	1.2	YES
10	7D Physical Assault	4	1.2	YES
11	3C Suicide – attempted	4	1.2	YES
12	3C Suicide	3	0.9	YES
13	4D Neonate low risk pregnancy intrapartum	3	0.9	YES
14	4C Maternal low risk pregnancy intrapartum	3	0.9	YES
15	2A Use of contaminated drug(s)	2	0.6	YES
16	1A Surgery (invasive procedure) on wrong site (body part)	2	0.6	YES
17	4I Failure to communicate (other)	2	0.6	YES
18	5D Bedrail associated injury	2	0.6	YES
19	1E Intra- or post-operative permanent harm	2	0.6	YES
20	1B Surgery (invasive procedure) on wrong patient	1	0.3	Yes
21	1C Procedure complication(s)	1	0.3	Yes
22	3C Self harm	1	0.3	YES
23	5B No gas from system designated for gas to be delivered	1	0.3	YES
24	4H Specimen ID Error	1	0.3	YES
25	2A Use of contaminated biologic(s)	1	0.3	YES
	Total NQF events reported	**306**		
1	Voluntary for research HAI Other - specify	19	5.7	OTR
2	Voluntary for research Treatment delay	4	1.2	OTR
	Determined Not a Sentinel Event	2	0.6	NO
	Total events reported of all types	**331**	**100**	

Figure 1: Sentinel Event Type Totals in 2019 (from the event reporting forms)



Section II-b: Sentinel Event Annual Summary Report

This section provides information regarding the total number of sentinel events indicated by the health facilities as reported on the ASRSER as well as a breakdown of the event types.

Event Types and Totals

For the calendar year 2019, 142 facilities were expected to file. A total of 67 facilities have completed the annual summary sentinel events report (ASRSER), uploaded a copy of their Patient Safety Plan (PSP), and updated the designated Patient Safety Committee (PSC) reporters contact information, even if no sentinel event occurred (47%). There were 75 facilities that had not filed their ASRSER (53%). The end of the business day on March 1, 2020 **(NRS439.843,)** deadline was not enforced. In a normal year notices would be sent two weeks prior, on March 1, and every two (2) weeks there-after. As of May 27, 2020, of all the facilities that started completing the annual summary form, only one facility remains needing to finish a partial filing. This is a proactive, iterative dialog process between the SER Registrar and the contacts at the facilities, especially when meeting timeliness of reporting. These reporting medical facilities included the following:

Table 4: Annual Summary Report Record Classification 2019

Year of Record	Event Type	Count in CY 2019
2019	Facility Reported No Sentinel Events	30
2019	Facility Reported One Sentinel Event	11
2019	Facility Reported More than One Sentinel Events	26
2019	**Total Facilities Reporting (required)**	**67**
2019	Non Medical Facilities completing the Annual Report	30

Table 5: Annual Summary Report Sentinel Event Facility Types from Reports 2019

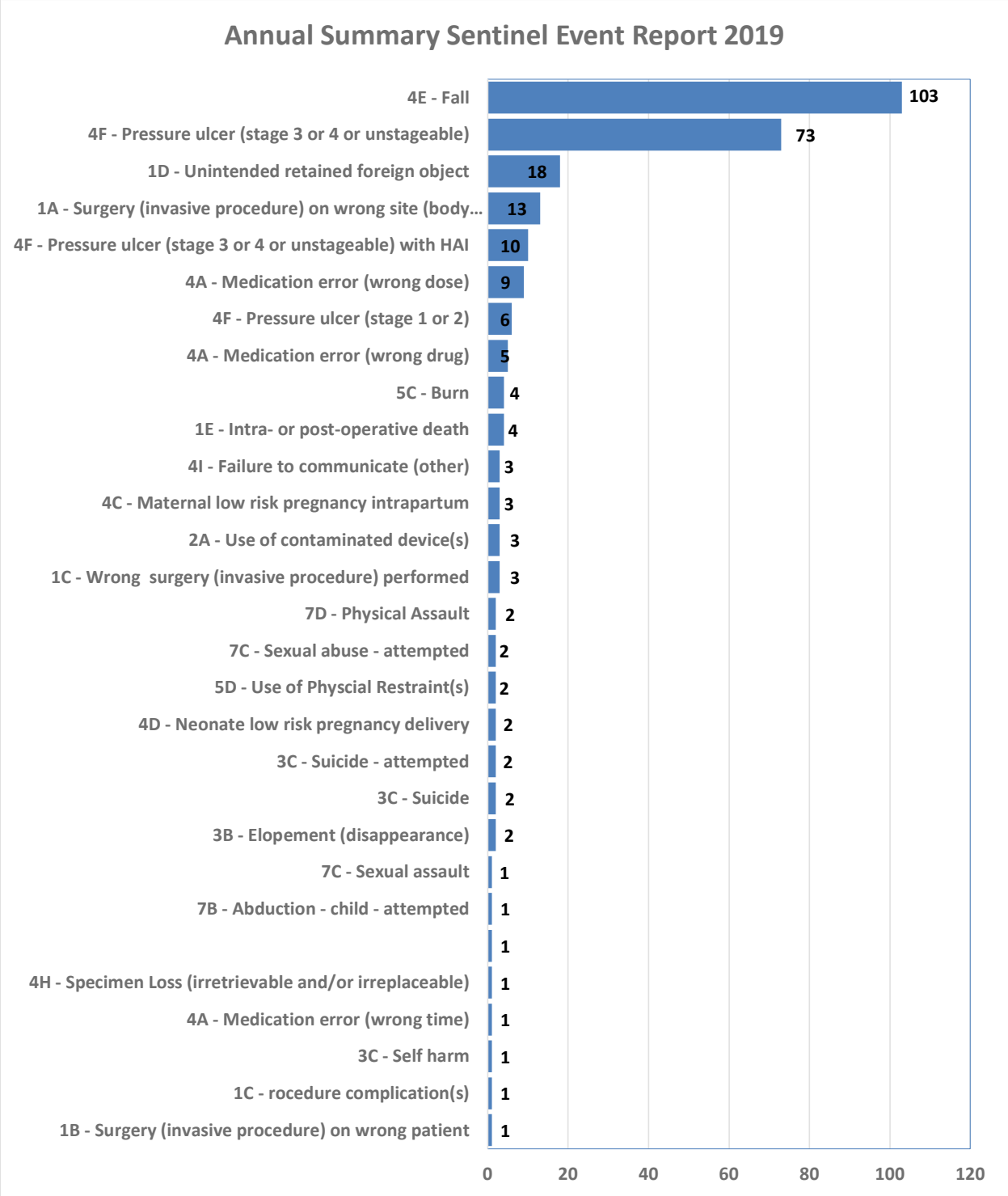
Facility Type	Facility Type Defined	Count of Facility Type	Count of Reported Events - Current Definition
ASC	Surgical center for ambulatory patients	24	19
HOS	Hospital	33	244
RUH	Rural Hospital	10	16
ALL	**Count of facilities and events**	**67**	279
	Not Required to Report, yet did report	**30**	9

Table 6 lists the types of sentinel events reportable with a total for each as indicated on the medical facilities' ASRSER. A percentage of all sentinel events reported is provided for each event type. In 2019, the medical facilities reported a total of 279 sentinel events out of 292 NQF, non-natural death and voluntary events reported on this form.

Table 6: Sentinel Event Type Totals in 2019 (from the annual summary forms)

Rank	Event	Count	Percent
1	4E – Fall	103	35.3
2	4F - Pressure ulcer (stage 3 or 4 or unstageable)	73	25
3	1D - Unintended retained foreign object	18	6.2
4	1A - Surgery (invasive procedure) on wrong site (body part)	13	4.5
5	4F - Pressure ulcer (stage 3 or 4 or unstageable) with HAI	10	3.4
6	4A - Medication error (wrong dose)	9	3.1
7	4F - Pressure ulcer (stage 1 or 2)	6	2.1
8	*Death - Not Natural*	*6*	*2.1*
9	4A - Medication error (wrong drug)	5	1.7
10	1E - Intra- or post-operative death	4	1.4
11	5C – Burn	4	1.4
12	1C - Wrong surgery (invasive procedure) performed	3	1
13	2A - Use of contaminated device(s)	3	1
14	4C - Maternal low risk pregnancy intrapartum	3	1
15	4I - Failure to communicate (other)	3	1
17	*V - Facility-acquired infection - (SSI) surgical site infection*	*3*	*1*
18	3B - Elopement (disappearance)	2	0.7
19	3C – Suicide	2	0.7
20	3C - Suicide – attempted	2	0.7
21	4D - Neonate low risk pregnancy delivery	2	0.7
22	5D - Use of Physical Restraint(s)	2	0.7
24	7C - Sexual abuse – attempted	2	0.7
25	7D - Physical Assault	2	0.7
26	*V - Other – specify*	*2*	*0.7*
27	1B - Surgery (invasive procedure) on wrong patient	1	0.3
28	1C - Procedure complication(s)	1	0.3
29	3C - Self harm	1	0.3
30	4A - Medication error (wrong time)	1	0.3
31	4H - Specimen Loss (irretrievable and/or irreplaceable)	1	0.3
32	5B - No gas from system designated for gas to be delivered	1	0.3
33	7B - Abduction - child – attempted	1	0.3
34	7C - Sexual assault	1	0.3
35	*V - Facility-acquired infection - (CAUTI) catheter-related urinary tract infection*	*1*	*0.3*
36	*V - Facility-acquired infection - other – specify*	*1*	*0.3*
	Total All Events	292	100
	Total NQF Events	279	0.3

Figure 2: Sentinel Event Type Totals in 2019 (from the annual summary forms)



Section III: Registry Data Analysis and Comparison between Summary Report and Registry Data

This section summarizes the data that has been received and recorded in the sentinel events registry individual incident reporting, and then compares the event types to data from the annual summary sentinel events reporting.

Event Types and Totals

Like Tables 3 and 6 above for 2019, Table 8 lists the types of sentinel events reported, including totals of the number reported according to both the summary forms and the reports recorded in the SER. In 2019, a total of 279 sentinel events were reported according to the summary forms versus 306 as recorded in the SER. These numbers reflect sentinel events only. These numbers do not include the categories of 'to be determined' or 'is not a sentinel event' nor any voluntary or non-natural death reporting.

Total Sentinel Events Summary Data vs. Registry Data (2015-2019)

From Table 7, the comparison of event counts between reporting methods for 2019 differ by about 9%, an increase in similarity compared to the previous year. In 2018 the difference was about 15%. In 2017 the difference was about 1%, followed by the 2016's difference of about 4%, and the 2015 difference at about 5% respectively.

Table 7: Total Events Summary vs. Registry (2015-2019)

Year	2015	2016	2017	2018	2019
Not Sentinel Events*	12	12	2	0	2
Registry Sentinel Events	270	323	277	262	306
Summary Sentinel Events	283	337	273	301	279
Difference	-13	-14	4	-39	27
Difference Percent	-4.81%	-4.33%	1.44%	-14.89%	8.82%

Remark:

See Figure 3 below for a graphical comparison of the relationship between the two reporting methods since 2015.

Figure 3: Total Sentinel Events Summary Report vs. Registry (2015-2019 all reports)

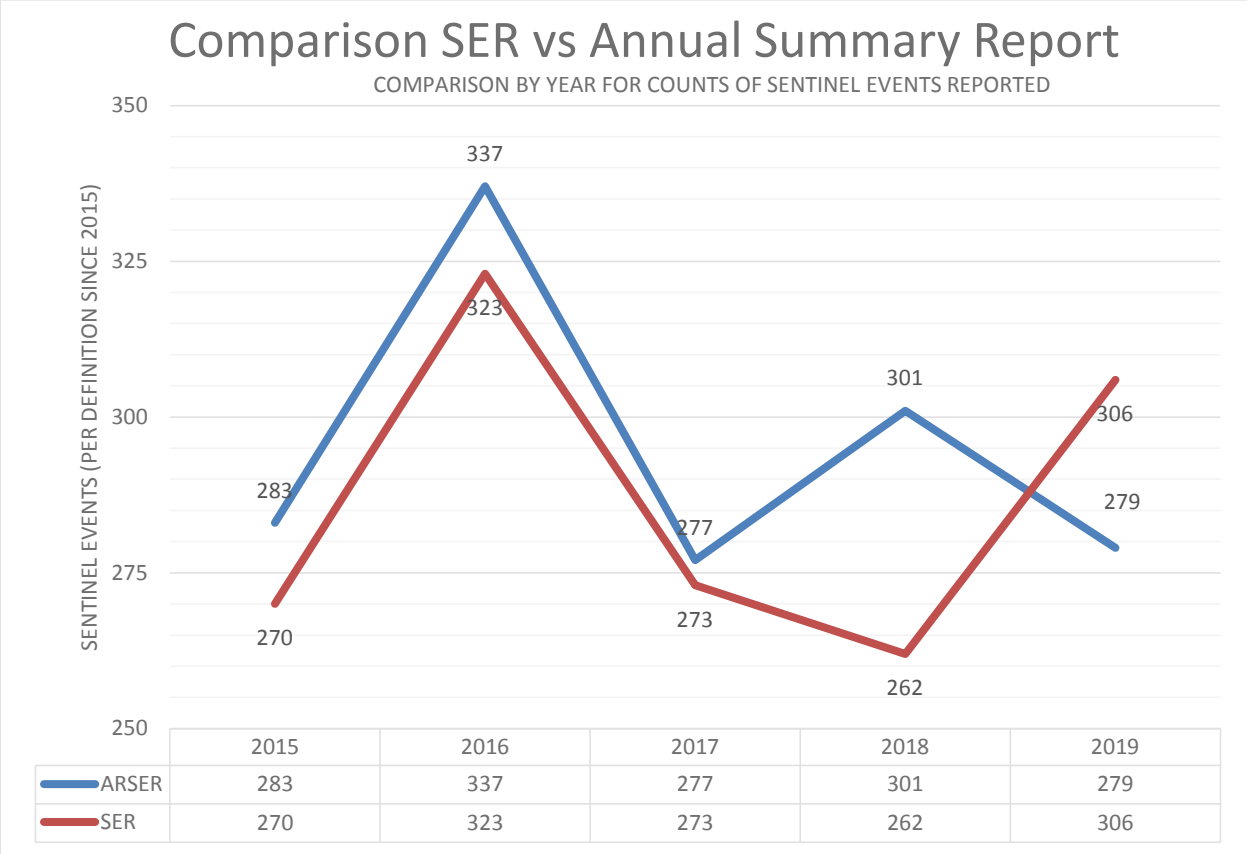


Table 8 – Sentinel Event Type Totals from the 2015-2019 Sentinel Event Report Summary Forms and Sentinel Events Registry

Description (*, **,***, ****)	2015 ASRSER	2015 SER	2016 ASRSER	2016 SER	2017 ASRSER	2017 SER	2018 ASRSER	2018 SER	2019 ASRSER	2019 SER
Abduction	0	1	1	0	0	0	0	0	1	0
Air embolism	0	1	0	0	0	0	0	0	0	0
Bedrail associated injury	0	0	0	0	0	0	0	0	0	2
Burn	4	5	8	8	13	14	9	9	4	5
Contaminated product or device or Drug	1	1	3	7	1	0	6	3	3	2
Device failure	6	7	6	5	1	1	3	4	0	0
Discharge to wrong person	0	0	0	1	3	3	1	1	0	0
Electric shock	0	0	0	0	0	0	0	0	0	0
Elopement	5	4	4	5	8	7	2	2	2	4

Failure to communicate	2	3	5	2	1	1	2	0	3	2
Fall	114	106	132	126	113	112	96	91	103	116
Impersonation of healthcare provider	0	0	0	0	0	0	0	0	0	0
Infant perinatal	9	0	7	0	5	0	0	0	0	0
Intra- or post-operative death	11	12	3	2	2	1	1	0	4	2
Introduction of metallic object into MRI area	0	0	0	0	0	0	0	0	0	0
Lost specimen	0	0	1	1	0	0	0	0	0	0
Maternal labor or delivery or intrapartum	3	3	2	1	1	1	1	1	3	3
Medication error or errors	8	6	7	8	15	11	25	6	15	6
Neonate labor or delivery or hyperbilirubinemia	9	7	7	1	5	3	0	0	2	3
Other - specify	0	0	0	2	0	12	12	12	0	0
Physical assault (attempted battery)	10	12	10	8	2	4	2	2	2	4
Pressure ulcer Stage 1 or 2 or 3 or 4 ****	68	67	91	94	58	63	99	90	89	98
Procedure complication or complications	0	0	0	1	0	3	0	0	1	1
Restraint	0	0	3	4	0	0	1	1	2	0
Retained foreign object	19	21	19	19	18	16	21	19	18	24
Self harm									1	1
Sexual assault	3	3	8	9	6	6	4	4	3	5
Specimen ID error									1	1
Suicide or suicide attempt	3	3	7	6	7	6	5	6	4	7
Surgery on wrong body part ****	6	8	8	10	8	2	7	0	13	2
Surgery on wrong patient	0	0	1	1	0	1	1	1	1	1
Surgery wrong procedure ****	2	0	3	1	5	9	2	9	3	15
Transfusion error	0	0	0	0	1	1	0	0	0	0
Use of contaminated biologic										1
Wrong or contaminated gas	0	0	1	1	0	0	1	1	1	1
Wrong sperm or egg	0	0	0	0	0	0	0	0	0	
Totals	**283**	**270**	**337**	**323**	**273**	**277**	**301**	**262**	**279**	**306**

*Columns bounded by thick borders indicate the same reporting year. White and blue backgrounds indicate the data source for the counts.

**Other counts were not included. Events for which no values were recorded in either data source are not included. Events deprecated as of the post-2013 sentinel event definition are not included.

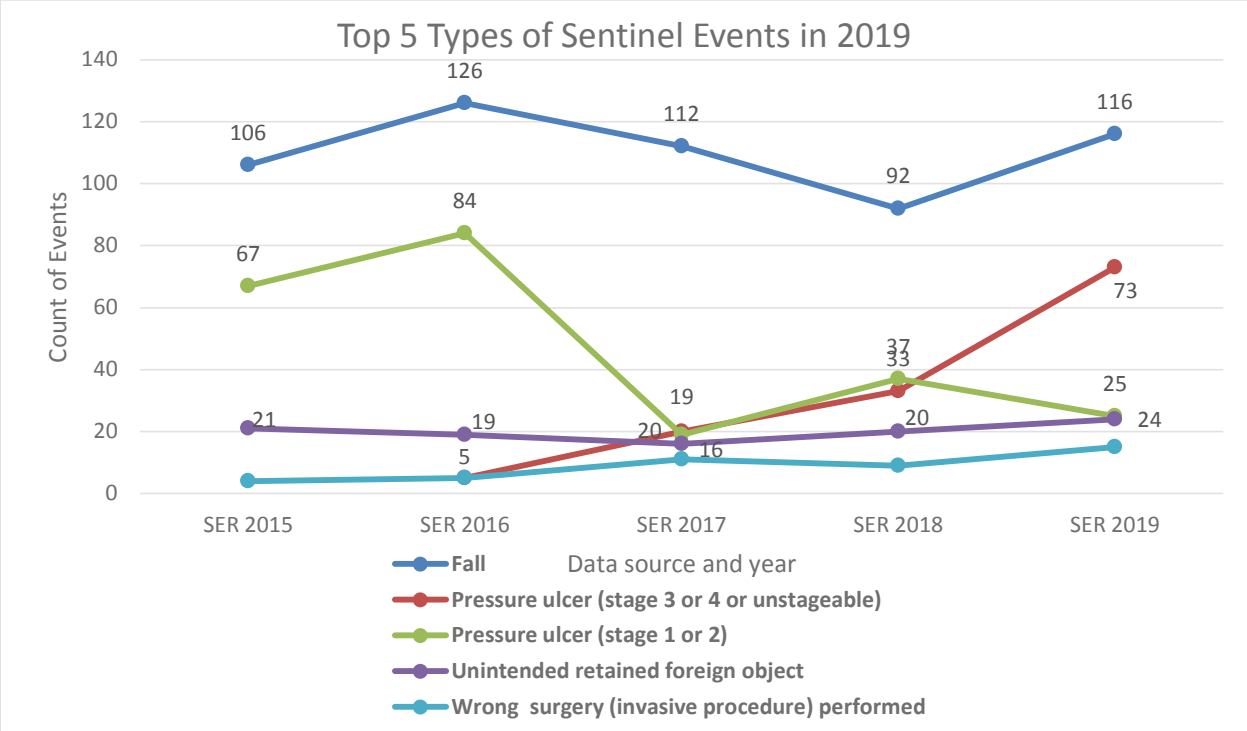
***Figure 3 illustrates the differences by total count per year.

**** Input form labeling may have caused some confusion.

Top 5 Types of Sentinel Events in 2019, Compared to Prior 5 Years

Figure 4 shows the top five (5) types of sentinel events in 2019 compared to the prior five (5) years. The data illustrated is only as a qualified event per the 2019 definition. From the graph, readers will notice that "Fall" is the number one type of event. Overall reported sentinel events stayed the same or increased reversing a three year trend. "Pressure ulcer" fluctuates, increasing in 2019 as happened in 2018. "Retained Foreign Object" increased slightly, exceeding the previous high from its 2016 level. Finishing the top five (5), "Surgery wrong procedure" increased again this year.

Figure 4: Top 5 Types of Sentinel Events in 2019, Compared to Prior 5 Years



Primary Contributing Factors in 2019

For each sentinel event, a maximum of four contributing factors may be entered. In 2019, there were 782 primary factors that contributed to sentinel events, which included patient-related, staff-related, communication/documentation, organization, technical, environment, and other primary contributing factors. Table 9 and Figure 3 show the top three primary contributing factors as:

- Patient related: 286 (37%)
- Staff related: 266 (34%)
- Communication/documentation: 135 (17%)

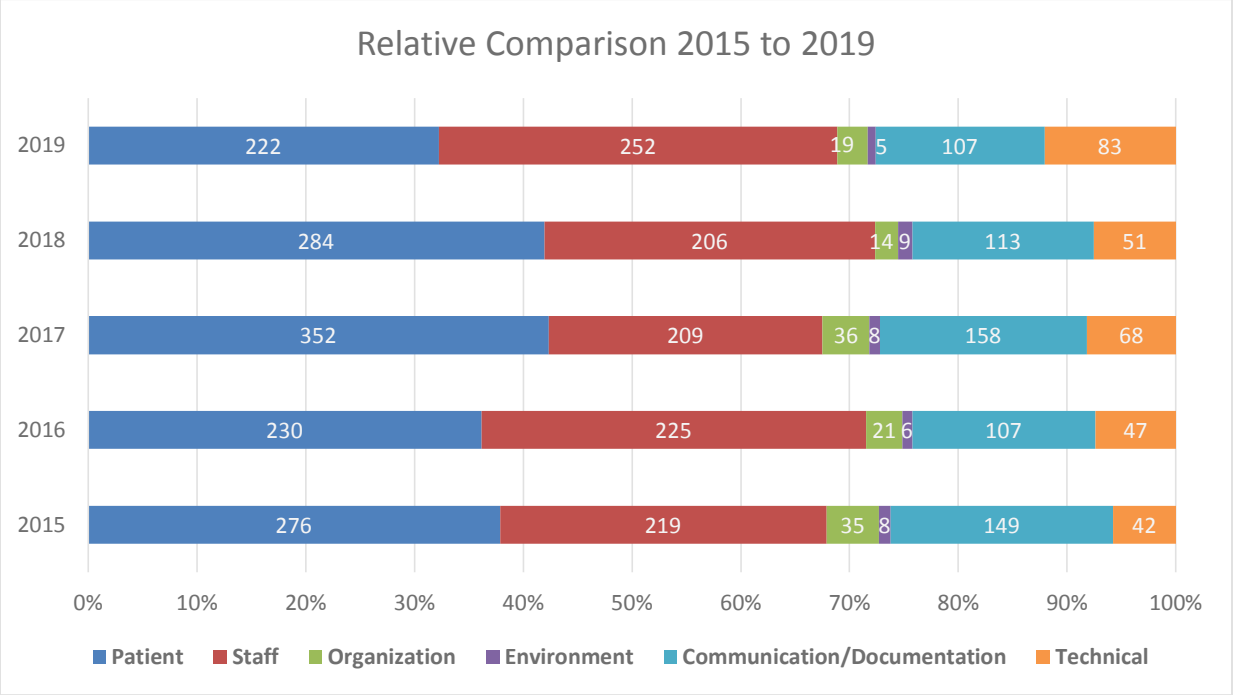
These three (3) factor area groups constitute greater than 88% of the total primary contributing factor groups in 2019. Comparing with 2018, patient-related returned to the top spot, which it also held in 2017. On a percentage basis Environment and Communication/Documentation decreased slightly while, Organization and the Technical factor area increased.

Table 9: Primary Contributing Factors from 2015 to 2019

Factor Area	2015 factor count	2015 percent	2016 factor count	2016 percent	2017 factor count	2017 percent	2018 factor count	2018 percent	2019 factor count	2019 percent
Patient	230	36.2	352	42.4	284	41.9	222	32.3	286	36.6
Staff	225	35.4	209	25.2	206	29.8	252	36.6	266	34
Organization	21	3.3	36	4.3	14	2.1	19	2.8	46	5.9
Environment	6	0.9	8	1	9	1.3	5	0.7	6	0.8
Communication/Documentation	107	16.8	158	19	113	16.9	107	15.6	135	17.3
Technical	47	7.4	68	8.2	51	5	83	12.1	43	5.5
SUM	636		831		677		688		782	100.0

Note: Each event can list up to 4 factors per factor area. Percent is proportion of all factors listed for that year. Percentages may not equal 100% due to rounding.

Figure 5: Primary Contributing Factors from 2015 to 2019 relative comparison



Note: Each event can list up to four (4) factors per factor area. The color bar represents the relative proportion of all factor group areas for each year.

Trends observed from the previous reports suggest that staff-related factors and patient-related factors consistently are first and second or vice versa, while communication and documentation have decreased slightly, technical issues appear to be increasing and organization issues and environment issues remain relatively less of a factor area. Longer term trends show technical issues increasing.

Detailed Primary Contributing Factors in 2019

Within the primary factor group areas there are many sub areas, referred to as 'detailed primary factors.' The detailed primary contributing factors in 2019 are displayed in Table 10. First in 2019 is Staff Failure Follow Policy or Procedure with 97 mentions, followed by Staff Clinical Decision Assessment, having 92, together accounting for nearly 25% of all detailed factors. Patient Frail Unsteady, Staff Clinical Performance Administration, and Patient Physical Impairment finish the top 5, accounting for an additional nearly 30% of all detailed factors. These few detailed factors consistently rank in the top 5 suggesting areas that could benefit from additional safety focused attention. In 2018 Staff Area Clinical Decision Assessment tops the list, and included Staff Area Failure to Follow Policy Procedure and Staff Area Clinical Performance Administration ranking staff area factors in the top three (3) selections followed by patient related factors before any mention of Environment, Organization, Technical or Communication/Documentation areas appear. As a contrast, in 2017 the factor Patient

Related Non-Compliant, with 83 events was the highest (12% of total events), Clinical Decision/Assessment contributed 80 events (just under 12% of the total events) and ranked second in 2017, while in 2016 this category was ranked first. Finishing 2017 in review, Failure to Follow Policy/Procedure ranked third with 74 events (11%) and Frail/Unsteady contributed to 63 events (9%) ranking fourth. Unfortunately, it appears that the top ranked primary factors fluctuate from year to year and that no consistent reduction of any specific primary factor has been achieved to date.

Table 10: Detail of Primary Contributing Factors in 2019

Factors (up to 4 per event can be selected)	2019 Counts	2019 Percent (%)
Staff Failure Follow Policy or Procedure	97	12.4
Staff Clinical Decision Assessment	92	11.8
Patient Frail Unsteady	74	9.5
Staff Clinical Performance Administration	74	9.5
Patient Physical Impairment	70	9
Patient Non Compliant	54	6.9
Patient Confusion	45	5.8
Communication-Documentation Lack Documentation	33	4.2
Communication-Documentation Handoff Teamwork	30	3.8
Communication-Documentation Verbal Inadequate	30	3.8
Communication-Documentation Lack Communication	26	3.3
Organization Verbal Inadequate	25	3.2
Technology Treatment Delay	14	1.8
Patient Medicated	12	1.5
Organization Culture Principles	10	1.3
Patient Psychosis	9	1.2
Patient Self Harm	8	1
Communication-Documentation Written Inadequate	8	1
Patient Alcohol Drugs	7	0.9
Technology Other	7	0.9
Technology Equipment Failure	6	0.8
Organization Inappropriate or No Policy	5	0.6
Communication-Documentation Written Incorrect	5	0.6
Technology Equipment Unavailable	5	0.6
Organization Staffing Level	4	0.5
Technology Equipment Incorrect	3	0.4
Technology Supplies Incorrect	3	0.4
Patient Allergy Known	2	0.3
Patient Language Barrier	2	0.3
Patient Line Cath Endo Tube Removed	2	0.3

Organization Exceeds	2	0.3
Environmental Emergency Internal	2	0.3
Environmental Noise Level	2	0.3
Technology Supplies Unavailable	2	0.3
Patient Allergy Unknown	1	0.1
Staff latrogenic error	1	0.1
Staff Pt ID	1	0.1
Staff Outside Scope of Practice	1	0.1
Environmental Emergency External	1	0.1
Environmental Floor Surface Wet or Slippery	1	0.1
Communication-Documentation Med Record incorrect	1	0.1
Communication-Documentation Transcription error	1	0.1
Communication-Documentation Verbal Incorrect	1	0.1
Technology Incorrect Med Route	1	0.1
Technology Labeling Ambiguous	1	0.1
Technology Test Results Incorrect	1	0.1
Total (detailed primary factors)	**782**	**100**

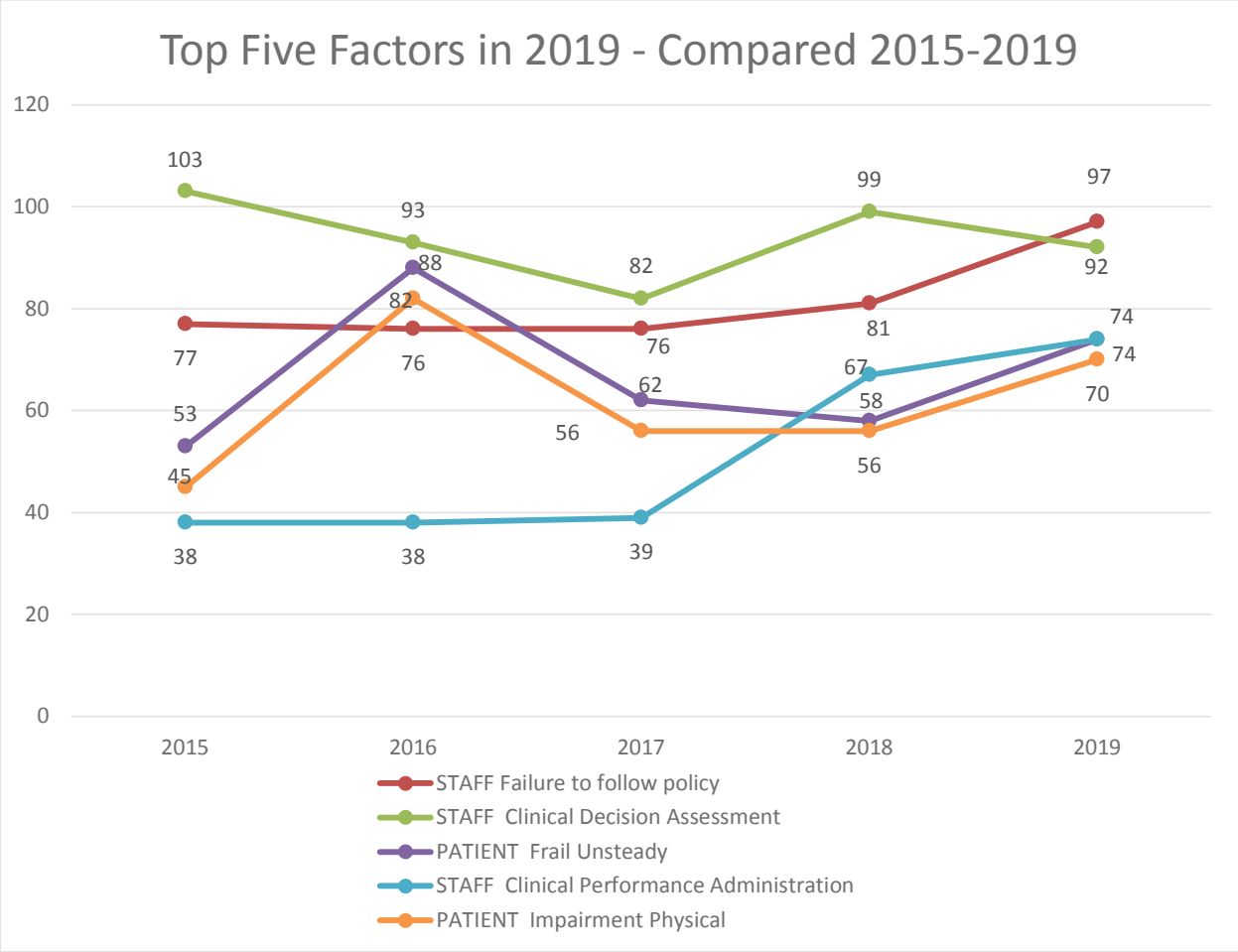
Top 5 Contributing Factors in 2019, compared to the prior 5 years

Table 11 and Figure 6 below show the top five (5) contributing factors in 2019 compared to the prior five (5) years. Each of the top 5 contributing factor categories this year continue from previous years, with only the sort order changing slightly. This illustrates the significance of potential improvements that could be achieved by focusing more efforts on staff policy awareness, assessment tools, and administration performance. Recognition and action around patient mobility and patient condition offer potentially meaningful improvements.

Table 11: The Top 5 Primary Contributing Factors in 2019, Compared to Prior 5 Years

Year	STAFF Failure to follow policy	STAFF Clinical Decision Assessment	PATIENT Frail Unsteady	STAFF Clinical Performance Administration	PATIENT Impairment Physical
2019	97	92	74	74	70
2018	81	99	58	67	56
2017	76	82	62	39	56
2016	76	93	88	38	82
2015	77	103	53	38	45

Figure 6: The Top 5 Primary Contributing Factors in 2019, Compared to Prior 5 Years



Note: This data uses the current sentinel event definition.

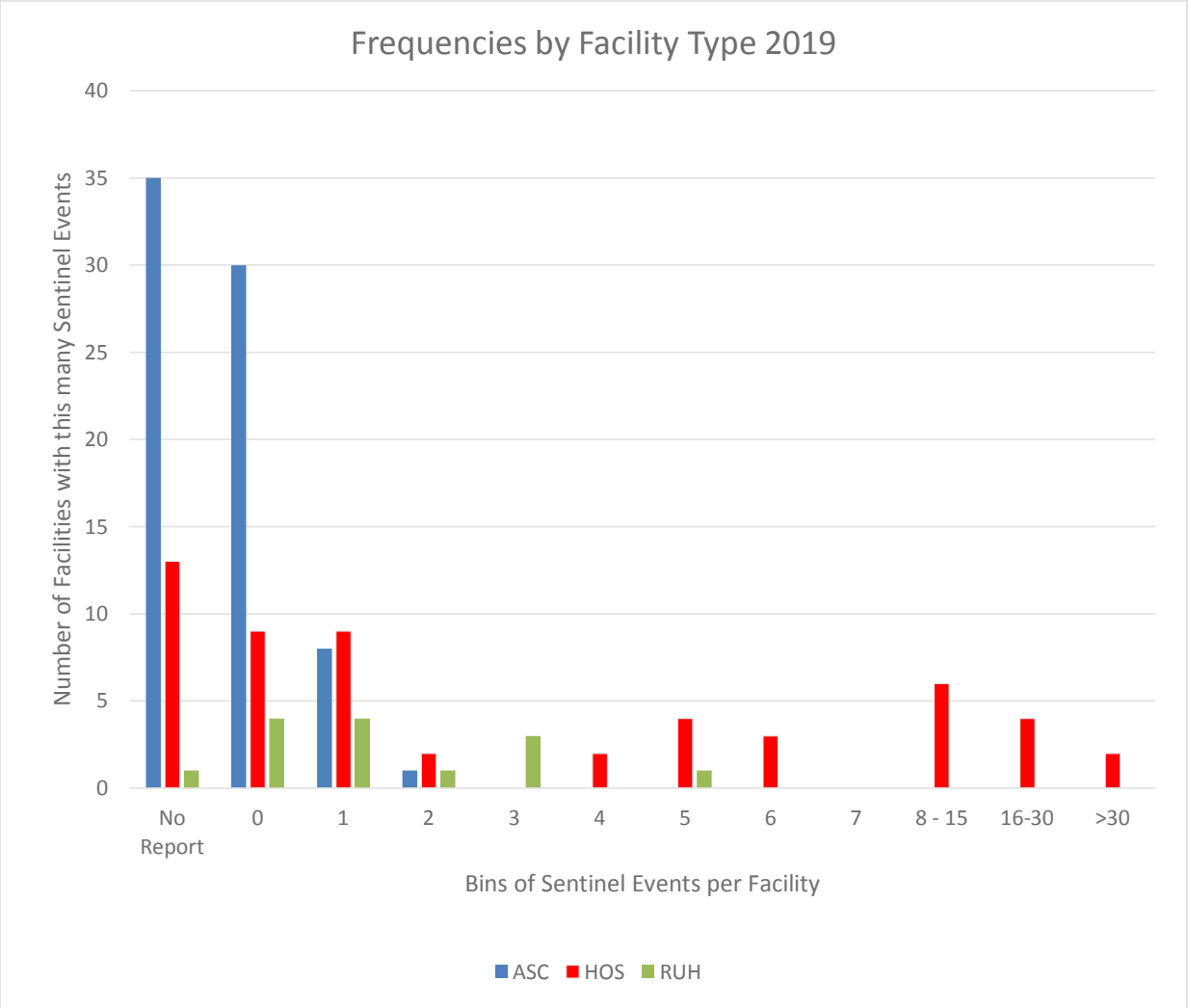
Distribution of Sentinel Events by Facility Type in 2019

Table 12 and Figure 7 illustrate the sentinel events for each type of facility in 2019 as counts. The following represent averages per year of reporting facilities. Surgical Center for Ambulatory Patients (ASC) showed an average of 0.25 events per reporting facility in 2019, notably different than 0.59 in 2018, 0.48 in 2017 and 0.17 in 2016. Hospitals (HOS), had an average of 6.7 events per reporting hospital, an increase from 4.70 in 2018, 4.78 in 2017 and 5.23 in 2016. Rural hospitals (RUH) have an average of 1.43 in 2019, another increase from 2018's 0.56, 2017's 1.07, but not quite as large as 1.71 in 2016.

Table 12: Sentinel Event Counts by facility type in 2019

Facility	Total	No Reporting	0	1	2	3	4	5	6	7	8 - 15	16-30	>30
ASC	74	**35**	**30**	**8**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
HOS	**54**	**13**	**9**	**9**	**2**	**0**	**2**	**4**	**3**	**0**	**6**	**4**	**2**
RUH	14	**1**	**4**	**4**	**1**	**3**	**0**	**1**	**0**	**0**	**0**	**0**	**0**

Figure 7: Frequency Counts of Sentinel Events by Facility Type

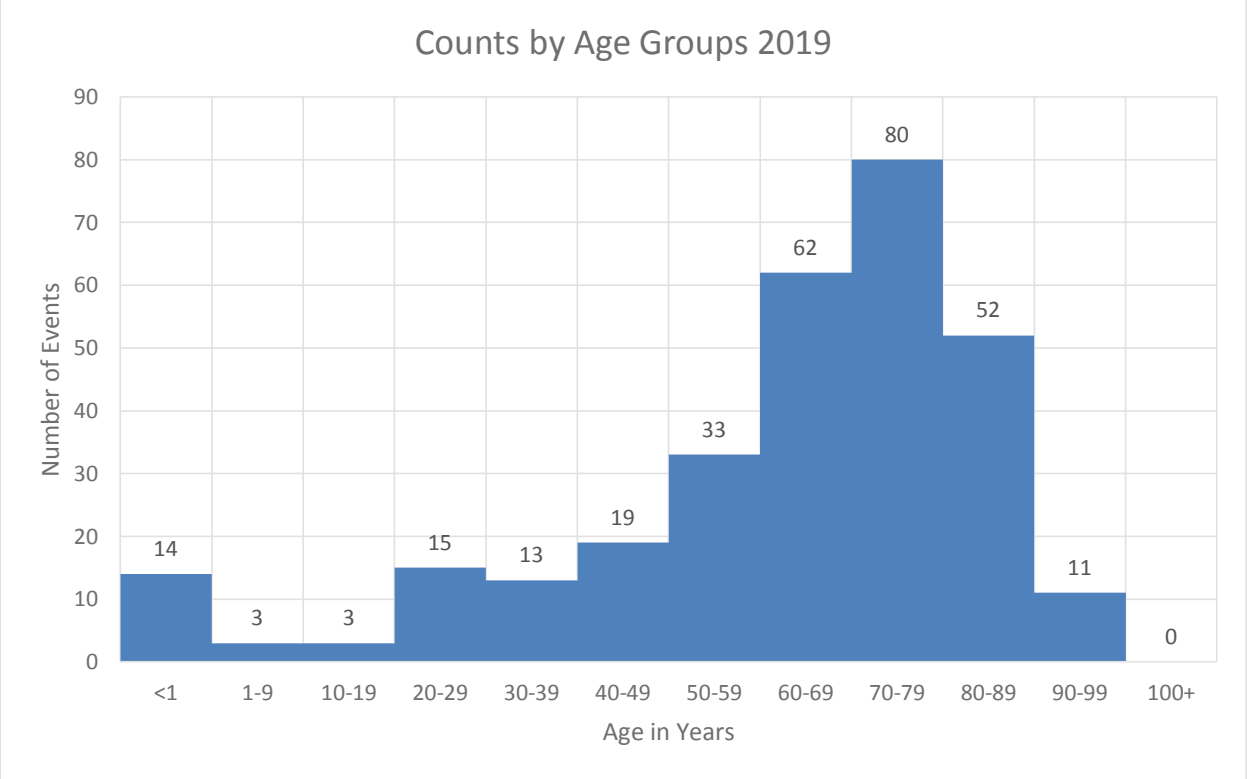


Sentinel Events by Age in 2019

Table 13: Sentinel Events by Age in 2019 (SER database)

Patient's Age	Count	Percent
<1 year old	14	4.6%
1-9 years old	3	1.0%
10-19 years old	3	1.0%
20-29 years old	15	4.9%
30-39 years old	13	4.3%
40-49 years old	19	6.2%
50-59 years old	33	10.8%
60-69 years old	62	20.3%
70-79 years old	80	26.2%
80-89 years old	52	17.0%
90-99 years old	11	3.6%
100+ years old	0	0.0%
Total (excludes missing DOB)	**305**	(May not equal 100% due to rounding.) **100%**

Figure 8: Sentinel Events by Age in 2019 (SER database)



Sentinel Events in relation to total patient discharges

By taking the total discharges per facility and comparing that to the reported number of sentinel events, a range of quantified risks can be calculated.

This metric temporarily suspended due to COVID-19 telecommute impacting access to data.

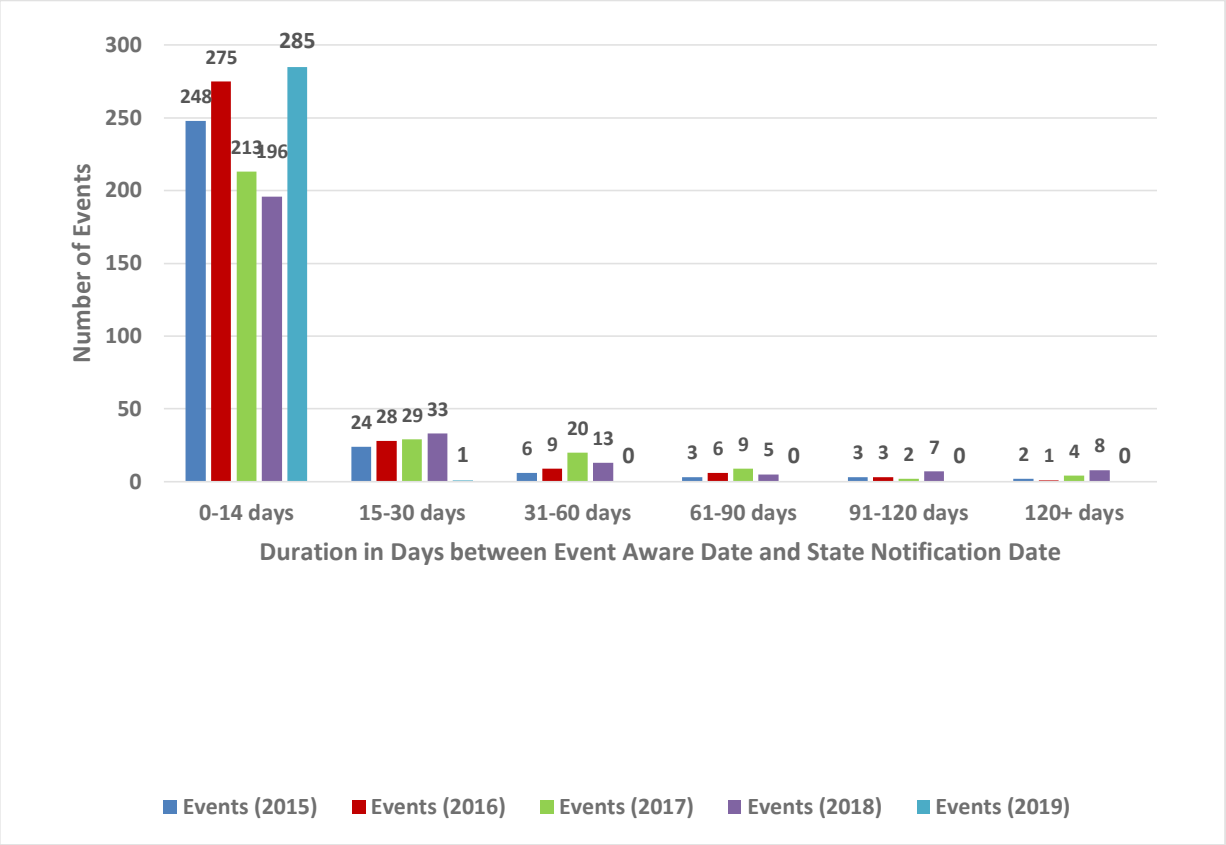
Duration in Days between Event Aware Date and Facility State Notification Date

According to **NRS 439.835**, facilities must notify the Sentinel Events Registry (SER) within 13 or 14 days depending upon if the patient safety officer or another healthcare worker discovers the event. Table 14 and Figure 9 show that in 2019 285 (99.65%) events were informed to the SER within the expected 14 days. Yet there were 22 bad data entries and 23 events without dates entered. Some of those may be non NQF. In 2018 75%, 2017 74% and in 86% in 2016 offer a range of diligent compliance over the years. Many of the events with data issues did not meet notification timelines.

Table 14: Duration between Event Aware Date and State Notification Date (SER database)

Duration	Events (2015)	Events (2016)	Events (2017)	Events (2018)	Events (2019)	Percent (2019)
0-14 days	248	275	213	196	285	99.65%
15-30 days	24	28	29	33	1	0.35%
31-60 days	6	9	20	13	0	0.00%
61-90 days	3	6	9	5	0	0.00%
91-120 days	3	3	2	7	0	0.00%
120+ days	2	1	4	8	0	0.00%
Bad Data					22	
No Data					23	
Total	**286**	**322**	**277**	**262**	**286**	100%

Figure 9: Duration between Event Aware Date and State Notification Date in 2015 to 2019 (SER database)



This is the Form 1 Report. (In 2019 had 22 bad data and 23 no data entries)

Duration in Days between SER Part 1 Form and Part 2 Form

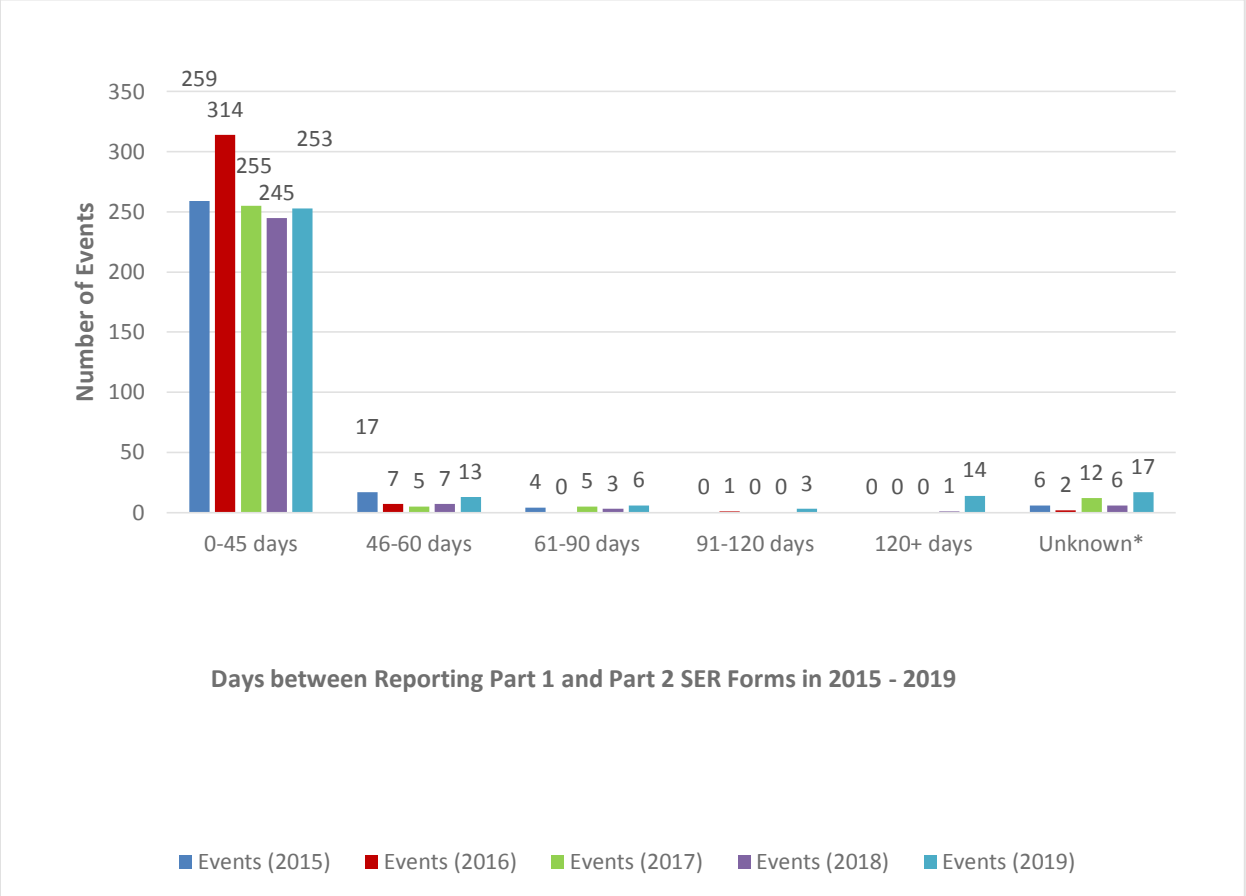
According to **NRS 439.835** within 14 days of becoming aware of a reportable event, mandatory reporters must submit the Part 1 form to the SER. Within 45 days of submitting the Part 1 form, the facility is required to submit the Part 2 form, which includes the facility's quality improvement committee describing key elements of the events, the circumstances surrounding their 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 an email to remind the medical facilities when the SER Part 2 form will be due.

Table 15 and Figure 10 illustrate that in 2019 nearly 83% met the requirements. While in 2018 just over 93%, 2017 at 92% and 97% in 2016 reported within the expected timeline. Seventeen (17) events are categorized as "unknown" since there are date data errors associated with those records.

Table 15: Reporting Duration in Days between SER Part 1 Form and SER Part 2 Form

Days between Part 1 and Part 2 SER Report Submission	Events (2015)	Events (2016)	Events (2017)	Events (2018)	Events (2019)	Percent (2019)
0-45 days	259	314	255	245	253	82.70%
46-60 days	17	7	5	7	13	4.20%
61-90 days	4	0	5	3	6	2.00%
91-120 days	0	1	0	0	3	1.00%
120+ days	0	0	0	1	14	4.60%
Unknown*	6	2	12	6	17	5.60%
Total Events	**286**	**324**	**277**	**262**	**306**	**100.00%**

Figure 10: Duration in Days between Reporting Part 1 and Part 2 SER Forms in 2015, to 2019



Duration in Days Between Event Aware Dates and the Patient Notification Dates and the Noticification Methods 2019

As shown in Table 16, patients affected by approximately 79% of the events were notified within one day as long as the facilities were aware of the occurrence of the sentinel events. Table 17 indicates that the predominant notification methods are telling the patient in person (231, 76%) or over the telephone (51, 17%).

Table 16: Duration in Days between Event Aware and the Patient Notification Date.

Duration (days)	Events	Percent
<1	242	79.10%
1 - 2	9	2.90%
3 - 5	6	2.00%
6 - 8	6	2.00%
8+	4	1.30%
Not notified or null entry or no entry* *Majority mention failed attempts to contact.	39	12.70%
Totals	**306**	**100.00%**

Table 17: Method of Notification to the Patient.

Notification methods	Events	Percent
Told in Person	231	75.50%
Telephone	51	16.70%
Not Notified	8	2.60%
Email	2	0.70%
Hand-Delivered Message	1	0.30%
No data or no next of kin	13	4.20%
Total	**306**	**100.00%**

Sentinel Events by Month in 2019

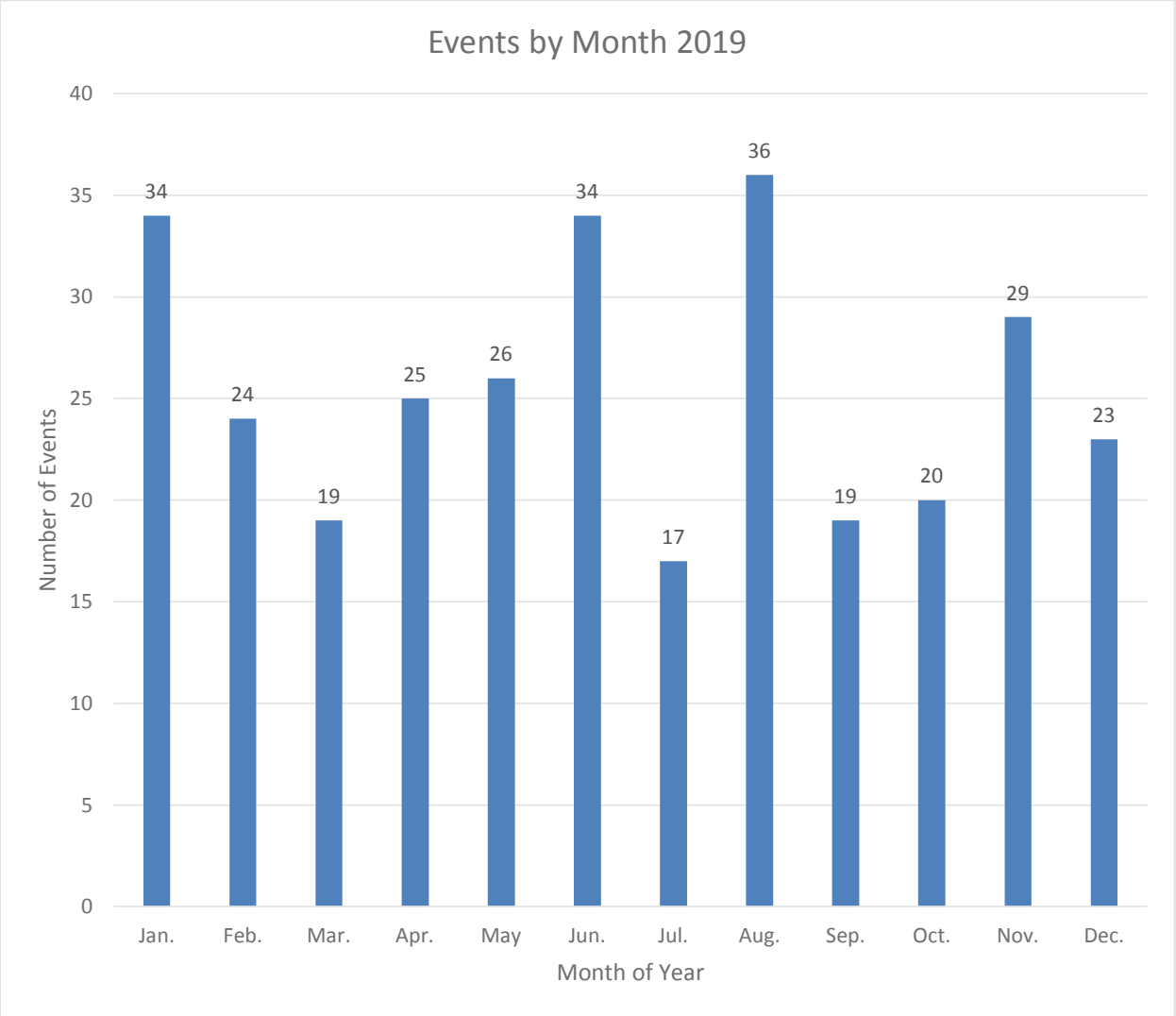
Table 18 and Figure 11 indicate that August was the peak month for sentinel event occurrence in 2019 (January for 2018, November for 2017, August in 2016, and January in 2015), 34% relative percent higher than the average of 25.5 events per month (average events per month: 22 in 2018, 27 in 2017, 27

in 2016, 24 in 2015), and 72% relative percent higher than the July count, which had the lowest number of sentinel events in 2019, as well as in 2018.

Table 18: Sentinel Events by Month in 2019 (SER database)

Month	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Total
Count of Events	34	24	19	25	26	34	17	36	19	20	29	23	**306**

Figure 11: Sentinel Events by Month in 2019 (SER database)



Department or Locations where Sentinel Events Occurred in 2019

Table 19 indicates that the medical/surgical department had more than twice as many events as the next highest location. Intensive/critical care, intermediate care, ER, and inpatient surgery round out the top 5 locations accounting for about 2/3's of all events. Each event can attributed to at most 4 departments. 28 departments out of 34 reported at least one event. There were 52 events that listed no department.

Table 19: Department or Location Where Sentinel Events Occurred in 2019 (SER database)

Department/Location	Count	Percent
Medical/surgical	83	28
Intensive/critical care	39	13.2
Intermediate care	28	9.5
Emergency department	25	8.4
Inpatient surgery	21	7.1
Ancillary other	11	3.7
IP Rehabilitation	10	3.4
Ancillary other	9	3
Long term care	8	2.7
Psychiatry/behavioral health/geropsychiatry	8	2.7
Labor/delivery	7	2.4
Nursing/skilled nursing	7	2.4
Anesthesia/PACU	5	1.7
Postpartum	5	1.7
Imaging	4	1.4
Pulmonary/respiratory	4	1.4
Cardiac catheterization suite	3	1
Ambulatory Care	3	1
Pediatrics Intensive Care	3	1
Pediatrics	3	1
Endoscopy	2	0.7
Neonatel Level 3	2	0.7
Observational/clinical decision unit	2	0.7
Antepartum	1	0.3
Dialysis	1	0.3
Laboratory	1	0.3
Newborn Level 1	1	0.3
Total	**296**	**100**

Patient Safety Approaches in nearby States

There is a wide range of approaches to patient safety and quality between the states. A good starting place that lists most states can be found here. http://qups.org/index.html

California:

Adverse events in health care settings appear to be driven by public complaints. Apparently, there is no formal reporting mechanism from the California Department of Public Health, Center for Health Care Quality, Licensing and Certification program. In addition, the state has its own definition of Reportable Adverse Events. Based on website information and news articles it does appear that several facilities have been assessed significant monetary penalties related to medication errors, failing to protect against interpatient abuse, retained foreign objects, etc. https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/Reportable-Adverse-Events.aspx.

The California Hospital Association formed a semi independent entity, the Hospital Quality Institute (HQI) in 2013. This program offers the following. Created in 2008 by the California Hospital Association, the Collaborative Healthcare Patient Safety Organization (CHPSO) is a federally designated patient safety organization (PSO) dedicated to the elimination of preventable patient harm and improving the quality of health care delivery. Also available are educational opportunities.

Oregon:

The Oregon Patient Safety Commission (OPSC) has the Patient Safety Reporting Program where health care settings such as Ambulatory Surgery Centers, Hospitals, Nursing Faculties and Pharmacies may voluntarily report adverse events in complete confidentiality. For participation the facilities are provided the services of a Patient Safety System Analyst at no charge, and organizations meeting or exceeding PSRP recognition targets may be acknowledged on the OPSC website and can display a recognition emblem, signifying their achievement, on their own website.

https://oregonpatientsafety.org/psrp/about-psrp/

Idaho:

There are no initiatives or programs within the Idaho Department of Health and Welfare (IDHW) that specifically address patient safety or adverse event reporting.

Utah:

The Patient Safety Initiatives program is the Utah Department of Health's commitment to the goal of increased patient safety in health care facilities. Beyond simply reporting adverse events, there are separate additional reporting requirements related to the use of anesthesia. Interestingly, it appears that some aspects of the program deploy the REDCaps system. http://health.utah.gov/psi/index.html

Arizona:

The Arizona Department of Health Services has no formal reporting of adverse events in a health care setting. In 2003, the Arizona Legislature passed legislation requiring each health care institution to develop policies and procedures for '*reviewing*' reports made by health professionals regarding adverse events, including those related to malfeasance. The law did not require reporting to any regulatory authority, and it specifically extended protections to the reporter(s) against termination and/or retaliation for at least 180 days following the report to the institution, to JCAHO, or to a state regulatory authority. https://www.azleg.gov/arsDetail/?title=36 in article 11.

Section IV: 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 health care providers who provide treatment to patients in their facility of the plan and its requirements.

Not all medical facilities submitted some sort of document as a patient safety plan in response to the 2019 sentinel event report summary form. Sixty-one (61) patient safety plans were submitted from sixty-seven (67) Annual Summary Reports filed, out of one hundred forty two (142) facilities that are expected per NRS to file an annual summary sentinel event report. As was the case from 2009 to 2018, 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**. DPBH has prepared a base template for the Patient Safety Plan to help guide those facilities that are unable to build their own Patient Safety Plan (PSP).

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 comprised 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 health care 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 comprised of:

1) The patient safety officer of the medical facility;
2) At least two providers of health care 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.

An informal checking of a certain few facilities reporting 24 employees, accomplished by examining their public websites for information regarding employee counts suggest some entered values would not hold up if greater scrutiny were applied.

According to the summary reports provided by the medical facilities, 52 facilities in 2019 (84 in 2018) indicated they had 25 or more employees, and 15 facilities in 2019 (43 in 2018) indicated that they had fewer than 25 employees. Overall, the patient safety committees at 59 of the 67 facilities (88%) reporting, met as frequently as required. Among the facilities that had 25 or more employees, 44 (85%) of the patient safety committees met monthly. Among the facilities that had fewer than 25 employees, 15 (100%) of the patient safety committees met on a quarterly basis. Table 21 shows these figures.

Table 21: Compliance with Mandated Meeting Periodicity among Facilities 2019

Facilities Having 25 or More Employees and Contractors (2019)			Facilities Having Fewer Than 25 Employees and Contractors (2019)		
Monthly Meetings	**Total Facilities**	**Percentage**	**Quarterly Meetings**	**Total Facilities**	**Percentage**
Yes	44	84.62%	Yes	15	100.00%
No	8	15.38%	No	0	0.00%
Did Not Report	0	0.00%	Did Not Report	0	0.00%
Total	**52**	**100.00%**	**Total**	**15**	**100.00%**

Not all patient safety committees had the appropriate staff in attendance at the patient safety committee meetings. Table 22 shows this with attendance details. Table 22 also shows that some facilities that have 25 or more employees did have mandatory meeting attendance. The overall percent with mandatory meeting attendance was about 69%. Of those facilities with 25 or more employees, in 2019, 71% had mandatory staff in attendance, while only 60% of those with fewer than 25 employees met the criteria. To compare, in 2018 93%, in 2017 94% and, in 2016 84% of those facilities with 25 or more employees had mandatory staff in attendance when meetings were held. In 2018 89%, in 2017 96% and in 2016, 95% of those with fewer than 25 employees had mandatory staff attendance.

Table 22: Compliance with Mandated Staff Attendance among Facilities

Facilities Having 25 or More Employees and Contractors (2019)			Facilities Having Fewer Than 25 Employees and Contractors (2019)		
Mandatory Staff	**Total Facilities**	**Percentage**	**Mandatory Staff**	**Total Facilities**	**Percentage**
Yes	37	71.15%	Yes	9	60.00%
No	15	28.85%	No	6	40.00%
Did Not Report	0	0.00%	Did Not Report	0	0.00%
Total*	**52**	**100.00%**	**Total**	**15**	**100.00%**

Section V: Plans, Conclusion, and Resources

Plans and Goals for the Upcoming Year

Nevada's Sentinel Event Registry program uses a web-based sentinel event reporting system, the REDCap (Research Electronic Data Capture) database platform (free and HIPAA compliant). This replaced the previous submission of sentinel events via facsimile used prior to October 2016. Users of the web-based reporting tool REDCap continue to have optimum workflow issues. Identification of features, requirements, and enhanced work flows to improve the system are ongoing within the scope of what REDCap's single table database allows. Data uniformity and form validation, better dashboard information, improved metrics reporting, and ease of work flow are near the top of the improvements list.

A Sentinel Event Registry Frequently Asked Questions (FAQ) was prepared. It is being provided to patient safety officers and designated reporters as needed and is to be placed on the programs website. Work continues on improving the utilization of the FAQ document.

The Sentinel Event Registry's sentinel event toolkit is being replaced by the FAQ.

In 2020, the SER will continue to enhance the Sentinel Event Registry program in the following areas:

- Has rebuilt the data tables so that a single table contains all records for the Event Reporting and the Annual Summary Report, as well as, standardized pick lists when appropriate. This allows a single source of data truth. Issues with common selection lists for both the individual event and the annual summary report have been resolved. There will continue to be separate tables for the reporting of individual events (SER), and the annual summary reporting (ASRSER). Added forms in the sentinel event form to record RCA atomic information and how conclusions have been implemented has been generally well received.
- Continue to provide the technical assistance related to the REDCap reporting systems, the frequently asked questions, and consultations as requested. Review and update, bringing recommendations up to date with current best practice.
- The Frequently Asked Questions sections to be in a video format remains to be implemented.
- 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 preventable incidents, with the goal to help facilitate the improvement in the quality of health care for citizens in Nevada.
- Assist the educational activities designed to help facilities increase their skills in root cause analysis and process improvement related to sentinel events.
- Continue to identify and address data quality issues.
- Develop key point bulletins to address most common factors associated with the most common sentinel event types.

Conclusion

Sentinel event reporting focuses on identifying and eliminating serious, preventable health care setting 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 similar events from occurring in the future. The system was designed for continuous improvement to the quality of services provided by the facilities by learning from prior sentinel events to establish better preventive practices.

Improving patient safety is the responsibility of all stakeholders in the health care system, and includes patients, providers, health professionals, organizations, and government. The data analysis indicates that the total number of sentinel events reported has slightly decreased compared to previous years. The major categories of a fall and an ulcer tracked lower in absolute numbers, though still ranking at number one and two, the same as in previous years. Most of the facilities diligently followed the procedures and requirements to submit the reports and had patient safety plans.

The number of sentinel events reported by a facility reflects many aspects of the facility. Diligent, timely and complete reporting can sometimes give the impression that a facility may have measurable room for improvement, when in fact, the number simply represents greater accuracy in reporting.

The impact of SB457's implementation has yet to be fully realized. Progress is being made towards completing the onboarding and providing resources to address the SER as well as patient safety for the newly reporting health care facilities.

The impact of the COVID-19 pandemic on reporting diligence and data follow up remains to be fully addressed.

Resources

Safety Checklists for Patients –

1) Bring all important papers with you including any Medical Power of Attorney or Advanced Care Directives, any medication records, allergy records, past health condition records.
2) Try to have friends or family stay with the patient 24/7 as much as possible.
3) Ask questions. Hygiene, medications, supplements, allergies, known reactions.
4) If anything does not seem right, keep asking someone until you are satisfied.
5) Put tape with 'NO' on any 'twin' organs not involved.

Forms for the patient or patient's loved ones to help defend against preventable harm:

https://www.psqh.com/marapr05/pschecklist.pdf

https://armstronginstitute.blogs.hopkinsmedicine.org/2011/12/20/a-safety-checklist-for-patients/

https://www.aarp.org/health/doctors-hospitals/info-03-2012/patient-checklist-for-hospital-stay.html

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, is located at:
http://dpbh.nv.gov/Programs/SER/Sentinel_Events_Registry_(SER)-Home/

The National Quality Forum Topics in Sentinel Reporting Events is located at:
http://www.qualityforum.org/topics/sres/serious_reportable_events.aspx

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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