Joe Lombardo
Governor

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Director

2022 Sentinel Events Registry Summary Report

Office of Analytics
and
Division of Public and Behavioral Health

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Department of Health and Human Services

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Agenda

1. Sentinel event definition
2. Who should report sentinel events?
3. Data collection methods
4. Data and analysis results
5. Plans and goals
6. Conclusion

What is a Sentinel Event?

- Defined as a serious reportable event.

  -largely preventable, and harmful clinical events that should 'never' happen

- Events that are reportable are published by the National Quality Forum (NRS 439.830).
  - *Healthcare Acquired Infections no longer reported to State SER, but Federally since 2013*

- Reporting has been conducted in Nevada since 2000, with force of statute since 2011.

Who should report a Sentinel Event?

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, page 1666**)

Data Collection Methods

Using the Research Electronic Data Capture (REDCap) platform, Patient Safety Officers or their designated reporters enter data, reporting on individual events, the annual summary report, and the facility's contact information.

Individual Event Report Forms:

- Part 1 Initial report to sentinel events registry (notification), 14 days from event awareness
- Part 2 Factor Areas, Departments, and Root Cause Analysis findings, 45 days after notification

Summary Annual Report forms (March 1 for the previous calendar) :

- Summary Annual Report Form
- Patient Safety Plan
- **All health facilities are required to submit regardless of if an event an occurs**

Standardized list of reportable events as selection criteria, including category for Non-natural Death.

Data and Analysis results

Sentinel Event Registry Participation by Healthcare Facility Type, 2022

There are 1,776 Licensed Health Facilities in the State of Nevada.

Enrollment

- 522 of all Licensed Health Facilities enrolled with the SER
- 29% Enrolled

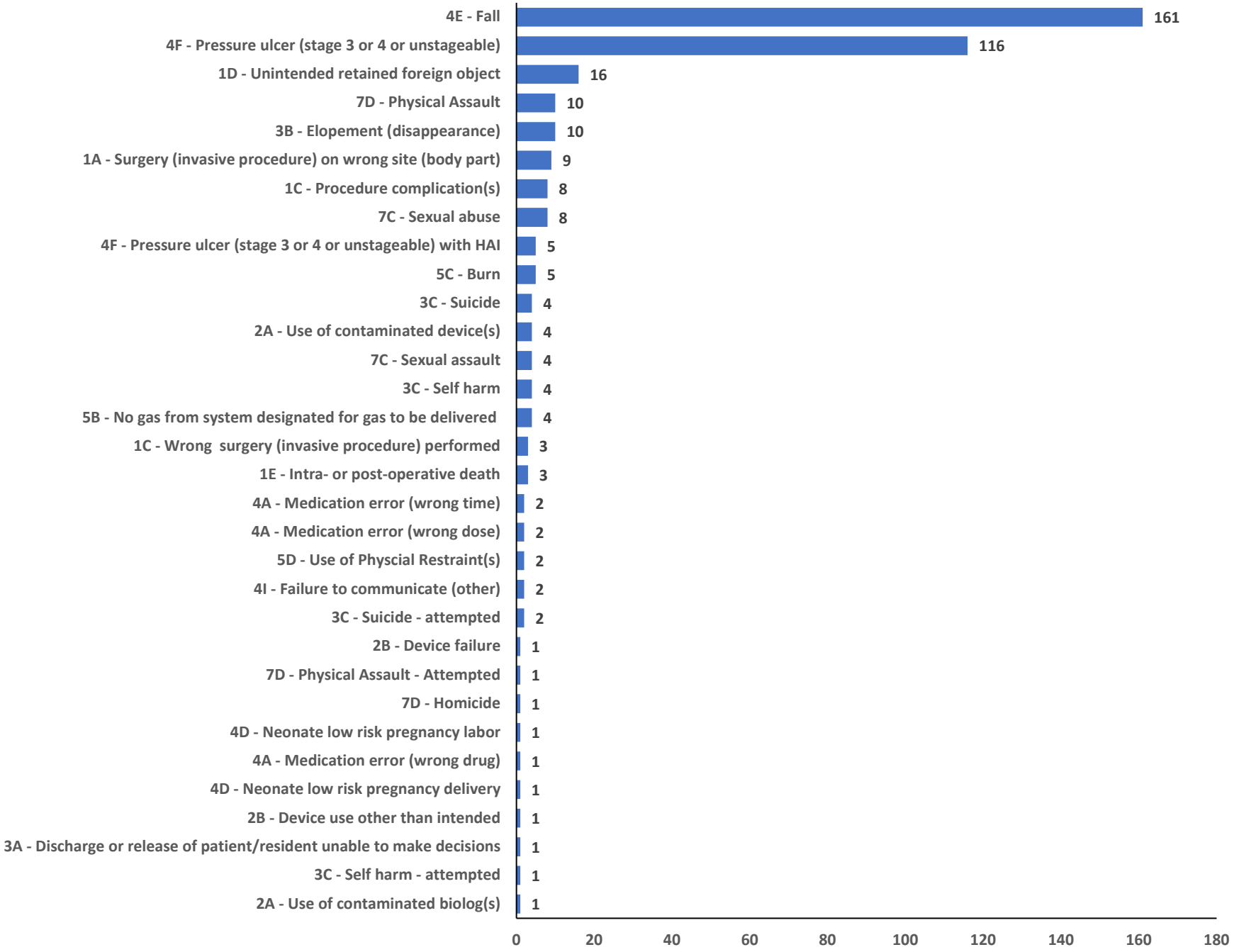
Participation

- 199 of the enrolled facilities participated in at least on reporting mechanism of the SER
- 38% of participation from the enrolled

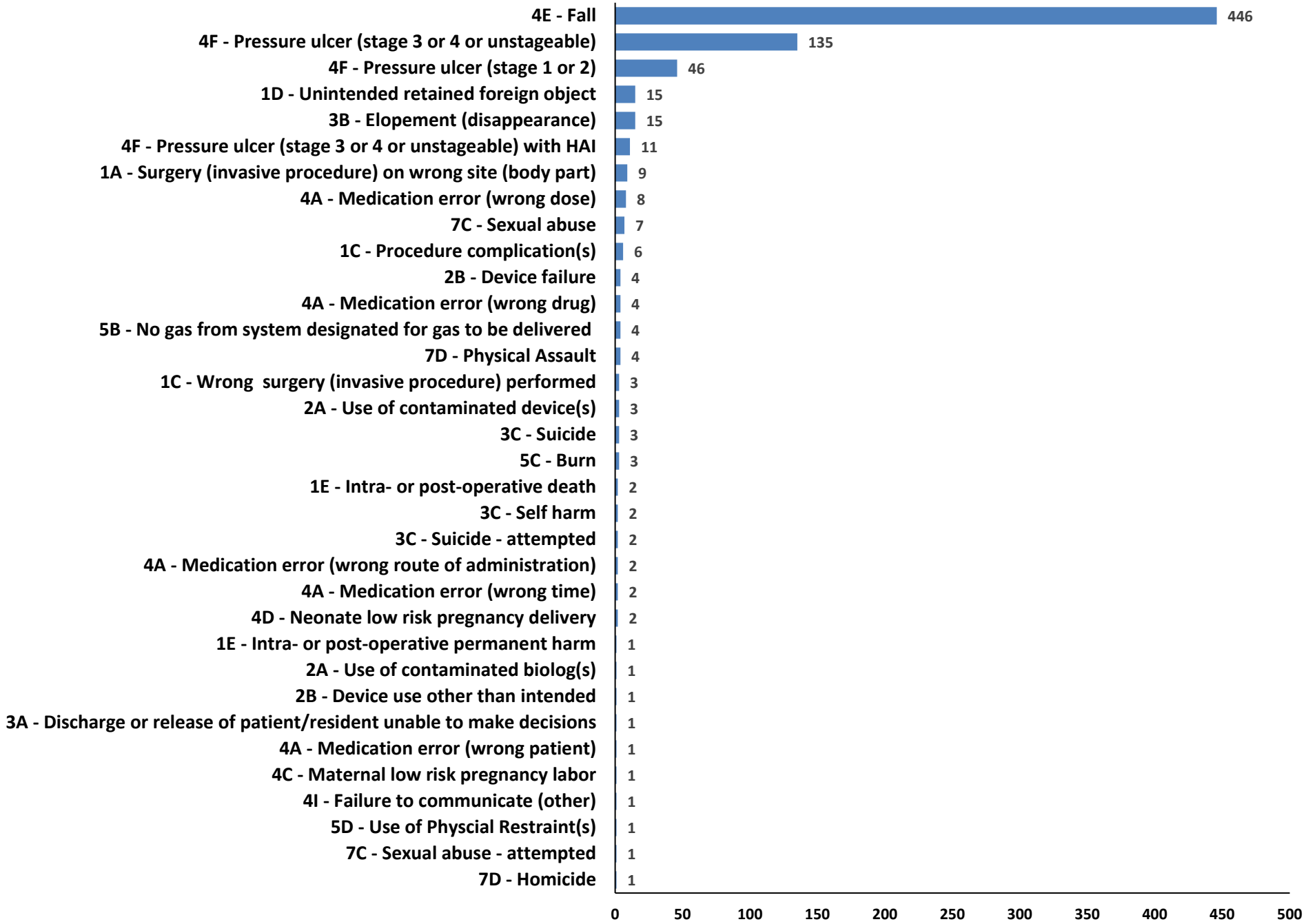
Key Findings

There are facilities that enroll in the SER, but do not report or participate beyond enrollment. The SER findings only include 11% of the total health care facilities in Nevada.

Count of Sentinel Events From Individual Reports



Count of Sentinel Events From Annual Reporting



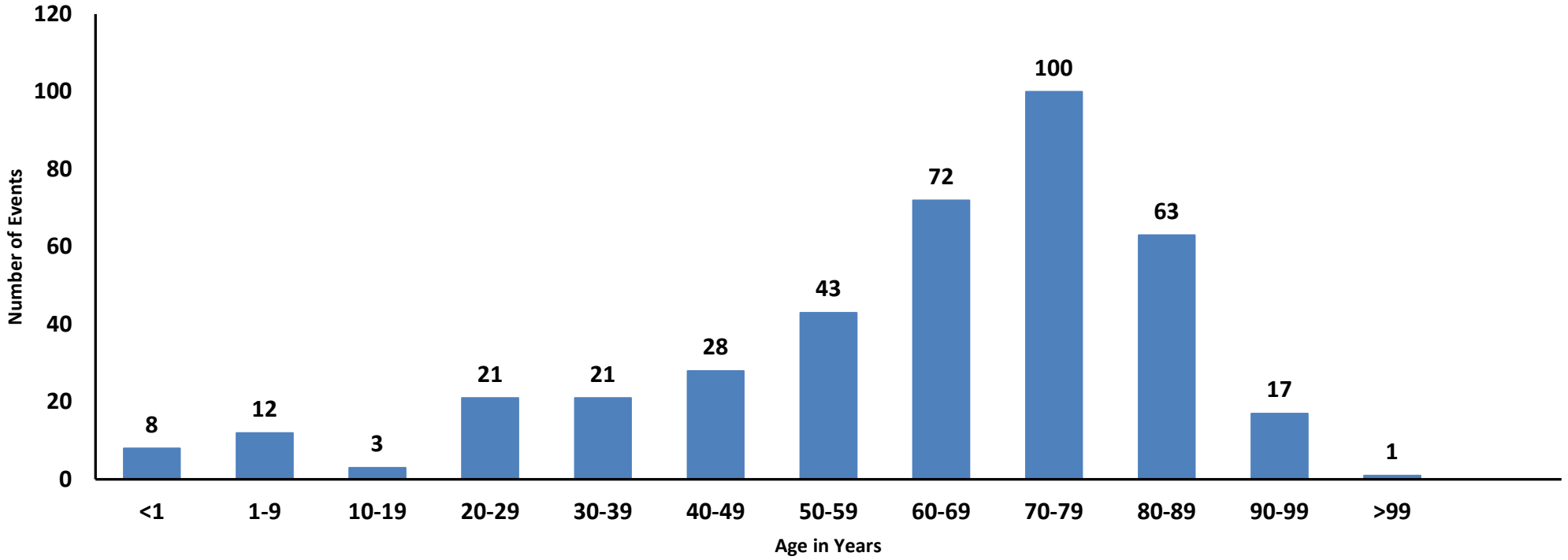
SER Participation and Proxy Counts

Due to the low participation rate, 187 facilities filed Annual Summary Reports and 60 facilities filed individual event reports (some filed both) in 2022, out of 1,776 licensed health care facilities, the exercise of producing a ‘ballpark’ proxy of actual events can be useful to sense the magnitude of adverse outcomes in the State of Nevada’s healthcare facilities.

A quick approximation of the true number of events in each category would apply a ‘proxy multiplier’ of 10.

The extrapolation exercise would give values like 446 to 4,400 falls, 135 to 1,350 Pressure Ulcers (Stage 3 or 4 or unstageable), 1 to 10 Homicides, and so forth.

Individual Sentinel Event



8 non-natural death

2 patients aged 30-39,

1 in each age group 40-49, 60-69, 70-79

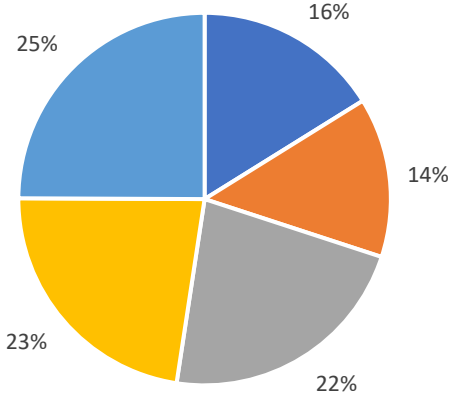
3 patients aged 90-99

41 patients died during their stay or within 24-hours of discharge for any reason

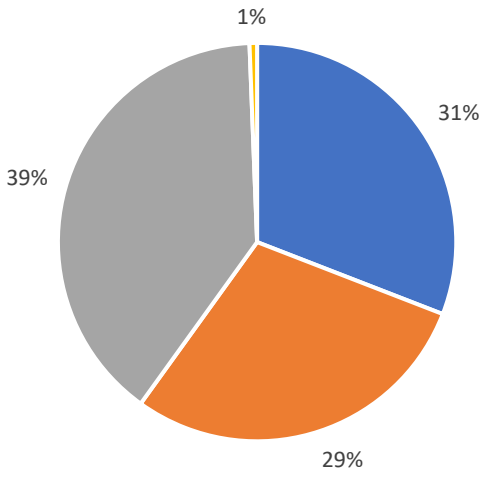
Detailed Factors Attributed

Patient, Staff and Organization Related

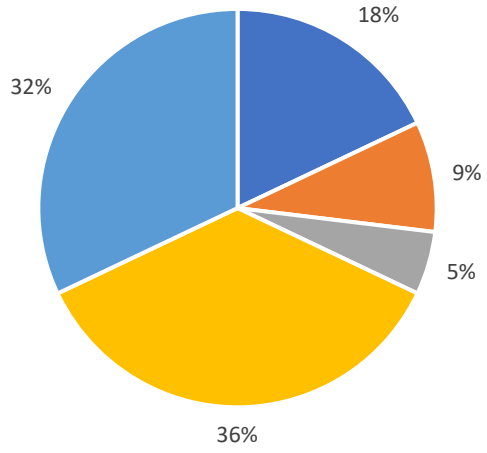
Patient-Related



Staff-Related



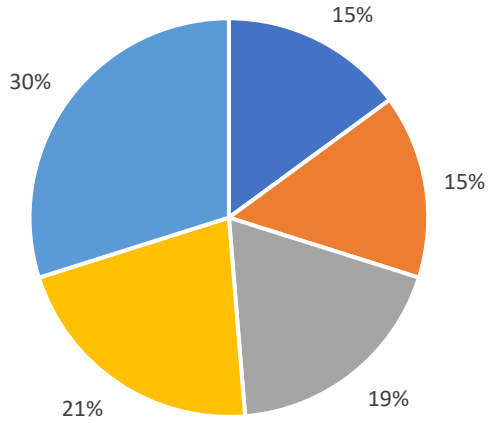
Organization-Related



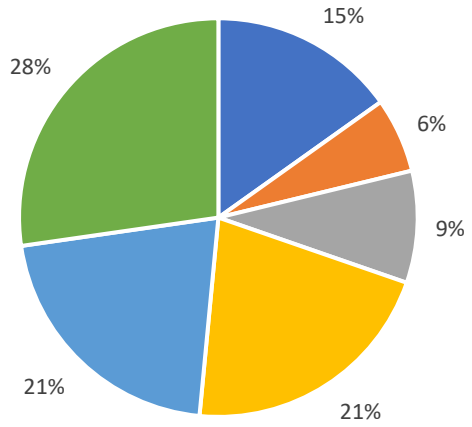
Detailed Factors Attributed

Communication/Documentation, Technical, and Environment Related

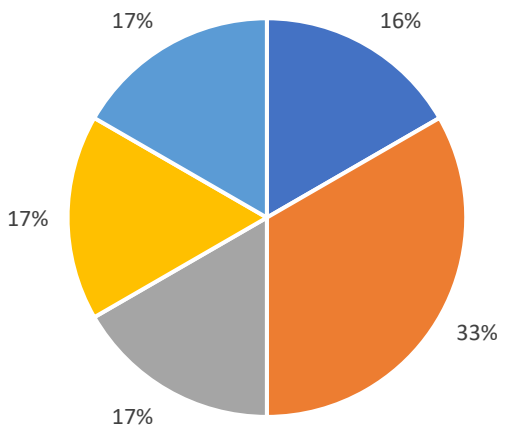
Communication/Documentation-Related



Technical-Related



Environment-Related



Frequency of Safety Meetings

Facilities Having 25 or More Employees and Contractors (2022)			Facilities Having Fewer Than 25 Employees and Contractors (2022)		
Monthly Meetings	**Total Facilities**	**Percentage**	**Quarterly Meetings**	**Total Facilities**	**Percentage**
Yes	**67**	**73.6%**	**Yes**	**77**	**80.2%**
No (Non-Compliant)	**23**	**25%**	**No**	**14**	**15%**
Did Not Report	**1**	**1.1%**	**Did Not Report**	**5**	**5.2%**
Total	**91**	**100%**	**Total**	**96**	**100%**

Safety Meeting Attendance

Facilities Having 25 or More Employees and Contractors (2022)			Facilities Having Fewer Than 25 Employees and Contractors (2022)		
Mandatory Staff	**Total Facilities**	**Percentage**	**Mandatory Staff**	**Total Facilities**	**Percentage**
Yes	61	67.0%	Yes	63	65.6%
No (Non-Compliant)	29	32%	No	28	29%
Did Not Report	1	1.1%	Did Not Report	5	5.2%
Total	91	100.0%	Total	96	100%

SER Event Lessons Learned

From Lessons Learned…

- ✓ Delay in treatment can lead to need for additional resources later, to address increase in severity of situation.
- ✓ During surge times, having basic cross training helps everyone fill in as needed.
- ✓ It is imperative to provide medication informed rights to the patient and anyone they designate as being responsible for them. All side effects must be presented.
- ✓ All new processes require additional scrutiny to ensure no bad outcomes.
- ✓ Training on de-escalation for altered patients improves outcomes.
- ✓ Despite patient answers on formal questions, observe behavior to inform risk assessment.
- ✓ Surgical trays should always be accounted for, even or especially, when considered a ‘simple routine’ procedure.
- ✓ At each shift change remind patients what is expected of them, and when they need to alert staff for help.
- ✓ Internal tensions must not impact professional communication.

SER Plans and Goals

The SER will work to improve health care facility participation in the following areas:

- When an unenrolled facility contacts non-SER staff for other purposes, the opportunity to enroll is presented.
- Management discussion regarding applying NRS language around financial penalties for failure to meet SER reporting expectations.

The SER will work to improve health care facility notification and outreach in the following areas:

- With additional staff support, follow-up phone calls can be made for health care facilities that do not respond within 2 weeks of the Annual Summary Report filing notification.
- The program's FAQ will be converted into short instructional videos.

SER Annual Report Conclusion

The Sentinel Events Registry focuses on helping health care facilities licensed by the Bureau of Health Care Quality and Compliance in identifying and eliminating serious, preventable incidents at their businesses.

The program is currently pro-active, and not punitive.

Reporting levels for the year 2022 were nearly the same as previous years. Issues that continue revolve around participation rates, funding to send regular mail notifications, staffing help, and data collection improvements.

Mandatory reporting, including reporting of sentinel events, lessons learned, corrective actions, and the patient safety committee activities are important for the State of Nevada to encourage disclosing that an event has occurred, and that appropriate action has been taken to prevent similar events from occurring in the future.

Improving patient safety is the responsibility of all stakeholders in the healthcare system, and includes patients, providers, health professionals, organizations, and government.

Contact Information

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Questions?