Sentinel Events Annual Summary 2022

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Office of Analytics

Department of Health and Human Services

Joe Lombardo
Governor
State of Nevada

Richard Whitley, MS
Director
Department of Health and Human Services

Contents

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Prepared by and Additional Information:

Office of Analytics
Department of Health and Human Services
State of Nevada

Thank you to following for providing leadership, data, and technical support for this report:

Jen Thompson
Health Program Manager II
Office of Analytics
Department of Health and Human Services
State of Nevada

Alexia Benshoof, MS
Health Bureau Chief
Office of Analytics
Department of Health and Human Services
State of Nevada

Jesse Wellman, BS
Biostatistician II
Office of Analytics
Department of Health and Human Services
State of Nevada

Sandra Atkinson
Health Resource Analyst II
Office of Analytics
Department of Health and Human Services
State of Nevada

For questions regarding this report please contact:

Sentinel Event Registry
Division of Public and Behavioral Health
4126 Technology Way, Suite 200, Carson City, NV 89706
Phone: 775-684-4112 or email: ser@health.nv.gov

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Background

A sentinel event is an action that should 'never happen' in a health care setting.

The purpose of the Annual Sentinel Events Summary Report is to comply with Nevada Revised Statutes (NRS) 439 and to inform the State Board of Health (BOH) and the public on patient safety as reported in the State of Nevada's Sentinel Events Registry (SER).

The Sentinel Events Registry was started in 2009 to inform the BOH and the public on the status of patient safety in Nevada. There are two required reporting mechanisms for sentinel events, individual reports and annual summary, and both are included in this report.

Nevada follows the Appendix A of **Serious Reportable Events in Healthcare--2011 Update: A Consensus Report 2011** published by the National Quality Forum. If the publication described above is revised, the "sentinel events" definition can be found in the most current version of the list of serious reportable events published by the National Quality Forum. Since 2019, non-natural deaths are reported to the SER but are not part of the National Quality Foundation definition.

Individual Reports

Each health care facility in Nevada is required to report individual sentinel events to the SER when the facility becomes aware that a sentinel event has occurred. 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 (up to a total of three authorized reporters allowed per facility).

Annual Summary Report (ASR)

Each health care facility is required to share an annual summary report of patient safety activities per calendar year, to be completed by March 1 of the following year. The annual report must include the total number and types of sentinel events reported by the medical facility, a copy of the patient safety plan, and a summary of the membership and activities of the patient safety committee.

For more information on the SER, see Nevada Revised Statutes 439.

Sentinel Events Reporting Overview

All health facilities are required to report all sentinel events as they occur with an individual report and an annual summary report annually by March 1st for the preceding year.

The count of facility types are the number of health care facilities licensed by the Bureau of Health Care Quality and Compliance (HCQC). Facilities are considered enrolled if they have contacted the SER at least once in the previous three years. To be considered a 'Participant,' a health care facility must have submitted at least one individual report and/or submitted the ASR for the reporting year. Similar facility types were combined in tables 1 and 2.

Hospitals, including rural hospitals, have the highest enrollment rate and participation rate in the SER. The total facility participation increased from 131 participants in 2021 to 199 (51.9%) in 2022. Table 1 Shows the counts and percents of the different types of facility to the SER.

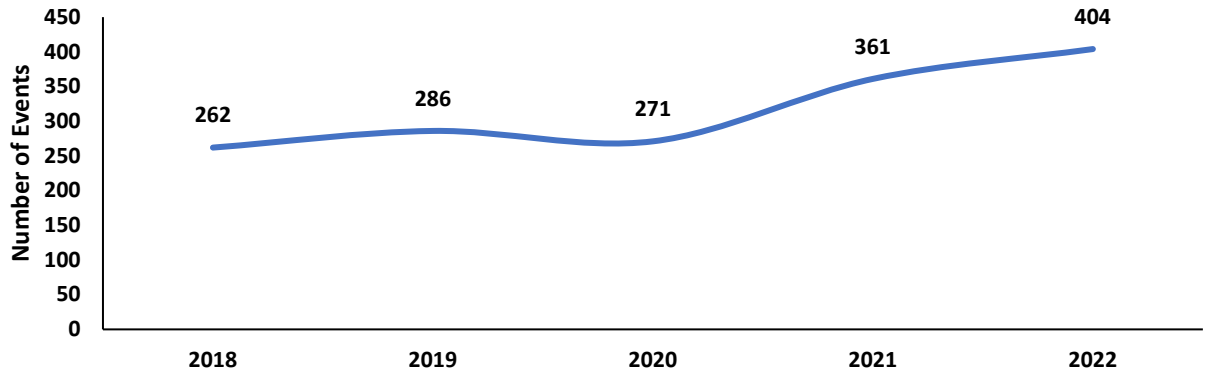
Table 1: Sentinel Event Registry Participation by Health Care Facility Type, 2022.

Facility Type Description	Count of Facility Type	SER Enrolled	SER Enrolled Percent	SER Participant	SER Participant Percent
Adult Day Care Facility	30	4	13.0%	0	0.0%
Alcohol or Drug Treatment Facility	22	8	36.0%	1	5.0%
Ambulatory Surgical Center	88	77	88.0%	29	33.0%
Community Triage Center	2	1	50.0%	0	0.0%
Domestic Violence Treatment Programs	27	0	0.0%	0	0.0%
Freestanding Birthing Center	1	0	0.0%	0	0.0%
Half-Way House for Recovering	9	0	0.0%	0	0.0%
Hospice Care Facility	187	32	17.1%	20	10.7%
Hospital	51	50	98.0%	39	76.0%
Independent Emergency Medical Care	1	1	100.0%	0	0.0%
Individual Residential Care Homes	121	13	11.0%	2	2.0%
Intermediate Care Facility	9	1	11.1%	1	11.1%
Medical Detoxification Facility	10	4	40.0%	0	0.0%
Medication Unit	1	0	0.0%	0	0.0%
Narcotics Treatment Facility	15	1	7.0%	1	7.0%
Nursing Care in the Home Agency	225	51	22.7%	23	10.2%
Nursing Pool	57	14	25.0%	11	19.0%
Outpatient Facility	51	18	35.0%	10	20.0%
Personal Care Agency	294	58	19.7%	14	4.8%
Psychiatric Residential Treatment Facility	15	0	0.0%	0	0.0%
Recovery Center Facility	3	2	67.0%	0	0.0%
Renal Disease Treatment Facility	55	33	60.0%	1	2.0%
Residential Group Facility	400	111	28.0%	26	6.0%
Rural Clinic	20	2	10.0%	0	0.0%
Rural Hospital	15	15	100.0%	12	80.0%
Skilled Nursing Facility	67	26	38.8%	9	13.4%
Total	**1,776**	**522**	**29.4%**	**199**	**11.2%**

Individual Sentinel Events

In 2022, 60 facilities reported 404 individual sentinel events, an increase in reported events from previous years and a 54% increase from 2018 (Figure 1).

Figure 1: Individual Sentinel Events Including Non-Natural Deaths, 2018-2022.



Of the 404 events in 2022, two were determined to be a non-sentinel event and 8 were non-natural deaths, which are included in the summary below but are not considered an event by the National Quality Foundation. There were ultimately 394 individual sentinel events counted for 2022 (Table 2).

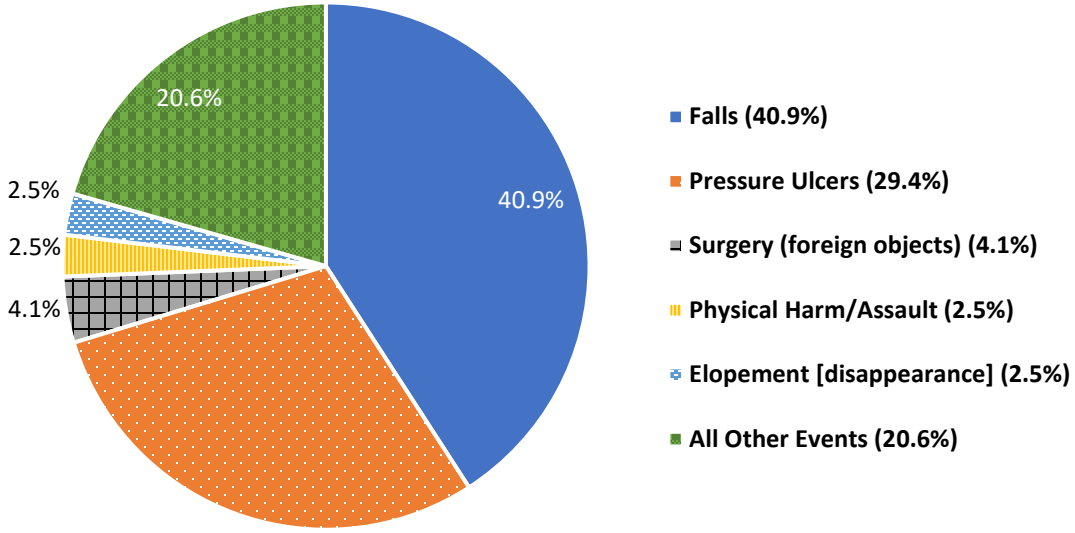
The number of facilities reporting individual events remains steady from the previous years, from 56 to 60 from 2021-2022.

Table 2: Individual Sentinel Events Reported by Health Care Facility Type, 2022.

Facility Type Defined	Count of Facilities who Reported	Not a Sentinel Event	Non Natural Deaths	Count of Facilities with Events	Count of Sentinel Events
Alcohol or Drug Treatment Facility	1	0	0	1	4
Ambulatory Surgical Center	5	0	1	5	20
Hospice Care Facility	6	0	1	5	8
Hospital	31	1	4	29	322
Narcotics Treatment Facility	1	0	0	1	1
Nursing Care in the Home Agency	1	1	0	0	0
Outpatient Facility	1	0	0	1	1
Residential Facility for Groups	3	0	1	3	9
Rural Hospital	7	0	0	7	22
Skilled Nursing Facility	4	0	1	3	7
Total	**60**	**2**	**8**	**55**	**394**

Data reported as an individual sentinel event must include an event that is classified by the National Quality Foundation (NFQ). In 2022, 40.9% of the events were Falls, followed by Pressure Ulcers at 29.4% of the reports. For the entire list of categories, type of events, and ranks see Appendix.

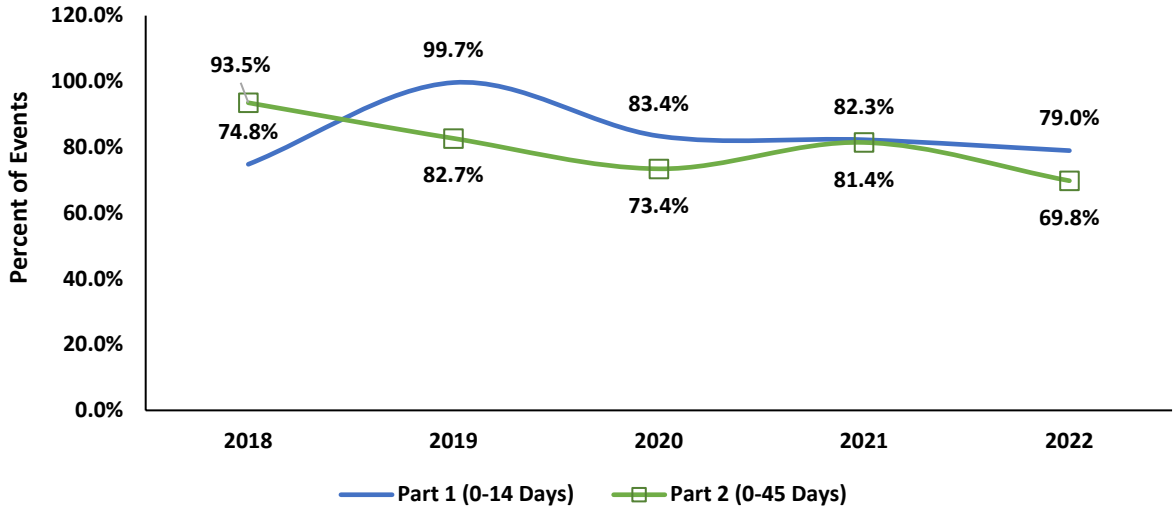
Figure 2: Sentinel Events by Type, 2022.



There are two parts to reporting an individual sentinel event. Part 1 is required to be submitted to the state within 14 days of the event. Part 2 is required to be submitted within 45 days of the event.

In 2022, just under 80% of the Part 1 events were reported in this proper timeframe which is down slightly from 82.3% in 2021. For Part 2, nearly 70% of the events were reported in the proper timeframe, which is down from 81.4% in 2021, a 14% decrease. The timeframe compliance has varied over recent years (Figure 3).

Figure 3: Individual Sentinel Events, Parts 1 and 2, Reported in the Proper Timeframe, 2018-2022.



Annual Summary Reports

Annual Summary Reports (ASR) are completed once a year and are required even if no sentinel occurred. The ASRs include information for all the various sentinel events that occur in a facility and include reporting related to patient safety meetings and patient safety plans.

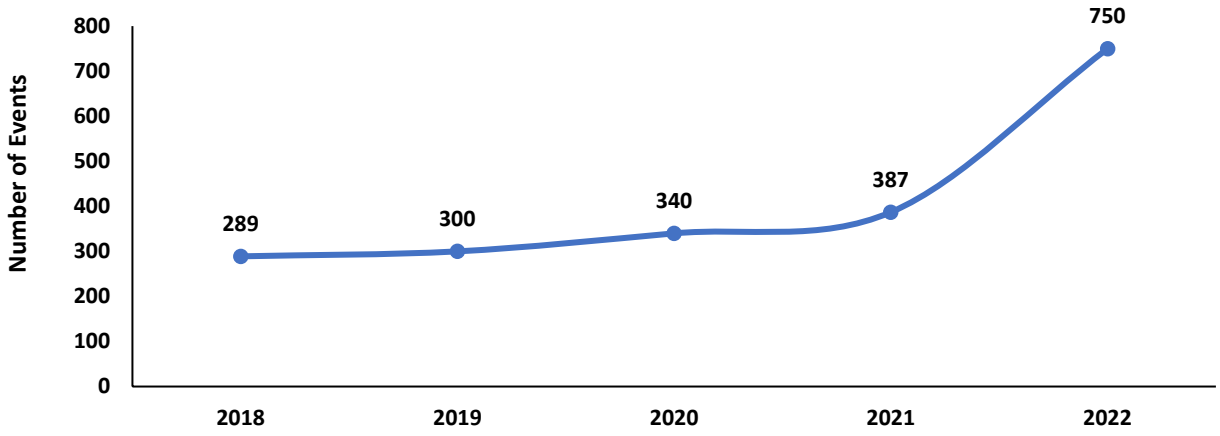
There are 1,776 facilities licensed by HCQC. All health facilities are required to report all sentinel events as they occur with the individual forms and an annual summary each year, by March 1st for the preceding year. In 2022, 1,589 facilities did not report, which represents roughly 90**%** of the facilities in Nevada. This is similar to the previous year where only 121 facilities. Table 3 below shows the show the participation for facilities in 2022.

Table 3: Annual Summary Report Counts, 2022.

Event Type	N.	%
Total Facilities Licensed by HCQC	1,776	
Number of Facilities that Did Not Report	1,589	89.5%
Number of Facilities that Did Report	187	11.8%
Of Those that Did Report (n=187)		
Had No Sentinel Events	130	69.5%
Had 1 Sentinel Event	20	10.7%
Had More than 1 Sentinel Events	37	19.8%

With ASR, facilities can report multiple events that occurred during the reporting year. In Table 3 (above), 37 facilities reported more than one event in 2022. There was a facility that had never reported before that reported a larger than expected number of falls causing the ASR events to increase significantly in 2022 (Figure 4).

Figure 4: ASR Events by Year Including Non-Natural Deaths, 2018-2022.



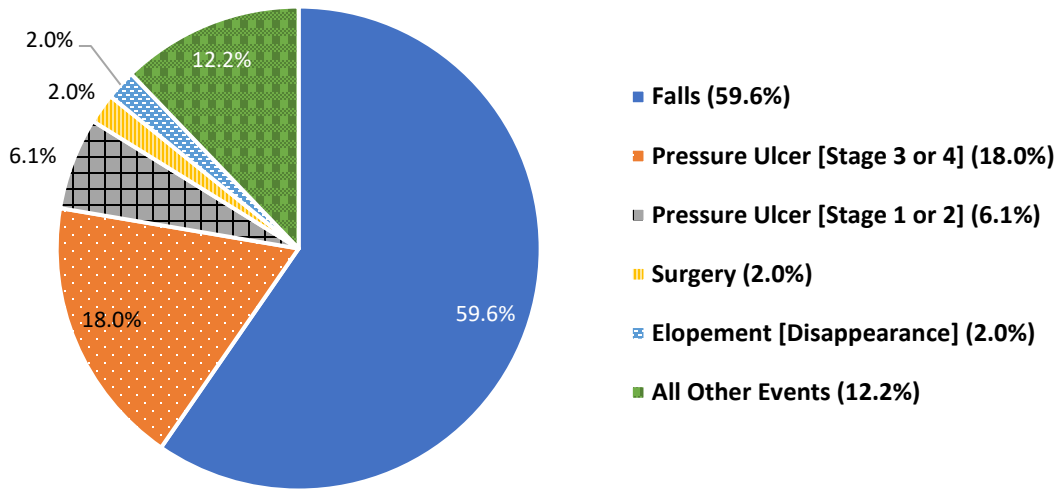
Hospitals have the best reporting to the SER out of all facility types. Of the 66 total hospitals and rural hospitals licensed by HCQC, 48 (73%) completed the ASR. The combined events reported by these hospitals make up 42% of the ASR events. Additionally, there were eight skilled nursing facilities which provided an ASR, and these reported 284 events, roughly 35% of the ASR sentinel event counts (Table 4).

Table 4: Annual Summary Report Counts by Facility Type, 2022.

Facility Type Defined	Count of Facilities who Reported	Non Natural Deaths	Count of Sentinel Events
Alcohol or Drug Treatment Facility	1	0	4
Ambulatory Surgical Center	28	0	28
Hospice Care Facility	15	1	10
Hospital	37	0	297
Individual Residential Care Homes	2	0	0
Intermediate Care Facility	1	0	0
Nursing Care in the Home Agency	23	0	58
Nursing Pool	11	0	1
Outpatient Facility	9	0	3
Personal Care Agency	14	0	12
Renal Disease Treatment Facility	1	0	0
Residential Group Facility	26	0	36
Rural Hospital	11	0	15
Skilled Nursing Facility	8	1	284
Total	**187**	**2**	**748**

Data reported as an ASR event must include an event that is classified by the National Quality Foundation (NFQ). In 2022, 59.6% of the events were Falls, followed by Pressure Ulcers (stage 3 or 4) at 18.0% of the reports (Figure 5). For the entire list of categories, type of events, and ranks see Appendix.

Figure 5: ASR by Type of Events, 2022.



Percentages may not add up to 100% due to rounding.

In the ASR, facilities can specify up to four contributing factors to the sentinel event. These factors can be grouped into Patient, Staff, Communication/Documentation, Organization, Technical, or Environment related.

The patient (36.6%) and staff (33.9%) contributed to roughly 70% of the ASR events.

Table 5: ASR Contributing Factors by Group, 2022.

Contributing Factors to Events	N.	%
Patient	353	36.6%
Staff	327	33.9%
Communication/Documentation	154	16.0%
Organization	78	8.1%
Technical	47	4.9%
Environment	6	0.6%
Total (Percentages may not add up to 100% due to rounding)	965	100%

When the facilities submit the ASR, they can include narrative about lessons learned. Below are these insights that may be helpful to other facilities in similar situations in the future.

- ✓ Review your policies and procedures, looking for anything not included.
- ✓ Starting a monthly internal inspection has resulted in identifying unsafe conditions and correcting them before any harm is done.
- ✓ Developing guides for physicians and clinical staff to incorporate patient safety into their routines has helped awareness of specific risks.
- ✓ Discussing 'what if' at the patient safety meeting has helped staff be better prepared if/when an event occurs.
- ✓ Knowing who to report events to, is confirmed at the patient safety meetings.
- ✓ Knowing when to ask/call for help makes a big difference in outcomes.
- ✓ When a product changes manufacturer, verify contents are comparable to previous product.
- ✓ Predefined action plans, including those who must be notified, helps prevent crisis.
- ✓ If the situation changes, then re-evaluation is the only right course.
- ✓ Remembering to double check measurements and matching to data entry can save lives.

Patient Safety Committees

As a component of the Annual Summary Report, facilities must report information about patient safety committees and submit a patient safety plan. All patient safety committees must report to the executive or governing body of the medical facility the number of sentinel events that occurred in the preceding quarter and provide recommendations to reduce the number and severity of the sentinel events that occurred at the facility.

A facility with 25 or more employees must have a patient safety committee that meets at least once each month. A medical facility that has fewer than 25 employees and contractors must establish a patient safety committee and meet at least once every calendar quarter. In Table 6, 77% of the facilities that reported the ASR did conduct patient safety meetings.

Table 6: Number of Facilities that Reported Having Patient Safety Committees Meetings, 2022.

Monthly/Quarterly	N.	%
Yes	144	77.0%
No	37	19.8%
Did Not Report	6	3.2%
Total	187	100.0%

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.

For 2022, 131 patient safety plans were submitted from 187 Annual Summary Reports filed, out of all facilities (1,776) that are expected per NRS to file an annual summary sentinel event report. The Division of Public and Behavioral Health (DPBH) has prepared a base template for the **Patient Safety Plan** to help guide those facilities that are unable to build their own.

Conclusion

The Sentinel Events Registry helps health care facilities licensed by the Bureau of Health Care Quality and Compliance (HCQC) to identify and eliminate serious, preventable events at their businesses.

Reporting to the SER, either individual or ASR has remained steady from year to year with roughly 11% of the required facilities reporting each year. Without more involvement from facilities, the SER cannot provide complete information regarding sentinel events in Nevada. Improving patient safety is the responsibility of all stakeholders in the health care system, including providers, health care professionals, organizations, patients, and government. By reporting and learning from prior sentinel events, new and better preventive practices can be established.

The SER will work to improve health care facility participation through increased communications with health care providers and possibly applying the NRS language around financial penalties for failure to meet SER reporting expectations.

Appendix

Table 1A: Individual Sentinel Events by Category, and Event, 2022.

Category	NQF Event Code	N.	%
Fall	4E - Fall	161	40.9%
Pressure Ulcer	4F - Pressure ulcer (stage 3 or 4 or unstageable)	116	29.4%
Surgery	1D - Unintended retained foreign object	16	4.1%
Physical Harm	7D - Physical assault	10	2.5%
Elopement	3B - Elopement (disappearance)	10	2.5%
Surgery	1A - Surgery (invasive procedure) on wrong site (body part)	9	2.3%
Surgery	1C - Procedure complications	8	2.0%
Sexual Related	7C - Sexual abuse	8	2.0%
Pressure Ulcer	4F - Pressure ulcer (stage 3 or 4 or unstageable) with HAI	5	1.3%
Burn	5C - Burn	5	1.3%
Self-Harm Related	3C - Suicide	4	1.0%
Use of Contaminated	2A - Use of contaminated device(s)	4	1.0%
Sexual Related	7C - Sexual assault	4	1.0%
Self-Harm Related	3C - Self harm	4	1.0%
Gas	5B - No gas from system designated for gas to be delivered	4	1.0%
Surgery	1C - Wrong surgery (invasive procedure) performed	3	0.8%
Intra- or Post-Operative Death	1E - Intra- or post-operative death	3	0.8%
Medication Error	4A - Medication error (wrong time)	2	0.5%
Medication Error	4A - Medication error (wrong dose)	2	0.5%
Restraint Related	5D - Use of physical restraints	2	0.5%
Failure to Communicate	4I - Failure to communicate (other)	2	0.5%
Self-Harm Related	3C - Suicide - attempted	2	0.5%
Device	2B - Device failure	1	0.3%
Physical Harm	7D - Physical assault - attempted	1	0.3%
Physical Harm	7D - Homicide	1	0.3%
Pregnancy	4D - Neonate low risk pregnancy labor	1	0.3%
Medication Error	4A - Medication error (wrong drug)	1	0.3%
Pregnancy	4D - Neonate low risk pregnancy delivery	1	0.3%
Device	2B - Device use other than intended	1	0.3%
Discharge	3A - Discharge or release of patient/resident unable to make decisions	1	0.3%
Self-Harm Related	3C - Self harm - attempted	1	0.3%
Use of Contaminated	2A - Use of contaminated biolog(s)	1	0.3%
Total (Percentages may not add up to 100% due to rounding)		**394**	**100.0%**

Table 2A: Location Where Individual Sentinel Event Occurred, 2022.

Department/Location	N.	%
Medical/Surgical	77	26.5%
Intensive/Critical Care	48	16.5%
Emergency Department	31	10.7%
Psychiatry/Behavioral Health	26	8.9%
Intermediate Care	23	7.9%
Nursing/Skilled Nursing	15	5.2%
Long Term Care	12	4.1%
Ancillary - Other	10	3.4%
Inpatient Surgery	10	3.4%
Outpatient/Ambulatory Surgery	9	3.1%
Inpatient Rehabilitation Unit	6	2.1%
Anesthesia/PACU	5	1.7%
Cardiac Catheterization Suite	4	1.4%
Imaging	4	1.4%
Labor/Delivery	4	1.4%
Endoscopy	1	0.3%
Laboratory	1	0.3%
Neonatal Unit (Level 3)	1	0.3%
Observational/Clinical Decision Unit	1	0.3%
Outpatient/Ambulatory Care	1	0.3%
Pediatric Intensive/Critical Care	1	0.3%
Pharmacy	1	0.3%
Total (Percentages may not add up to 100% due to rounding)	**291**	**100%**

Table 3A: Annual Summary Report Events by Category, and Event, 2022.

Category	NQF – Event Code	N	%
Fall	4E - Fall	446	59.6%
Pressure Ulcer	4F - Pressure ulcer (stage 3 or 4 or unstageable)	135	18.0%
Pressure Ulcer	4F - Pressure ulcer (stage 1 or 2)	46	6.1%
Surgery	1D - Unintended retained foreign object	15	2.0%
Elopement	3B - Elopement (disappearance)	15	2.0%
Pressure Ulcer	4F - Pressure ulcer (stage 3 or 4 or unstageable) with HAI	11	1.5%
Surgery	1A - Surgery (invasive procedure) on wrong site (body part)	9	1.2%
Medication Error	4A - Medication error (wrong dose)	8	1.1%
Sexual Related	7C - Sexual abuse	7	0.9%
Surgery	1C - Procedure complication(s)	6	0.8%
Device	2B - Device failure	4	0.5%
Medication Error	4A - Medication error (wrong drug)	4	0.5%
Gas	5B - No gas from system designated for gas to be delivered	4	0.5%
Physical Harm	7D - Physical Assault	4	0.5%
Surgery	1C - Wrong surgery (invasive procedure) performed	3	0.4%
Use of Contaminated	2A - Use of contaminated device(s)	3	0.4%
Self-Harm Related	3C - Suicide	3	0.4%
Burn	5C - Burn	3	0.4%
Intra- or post-operative death	1E - Intra- or post-operative death	2	0.3%
Self-Harm Related	3C - Self harm	2	0.3%
Self-Harm Related	3C - Suicide - attempted	2	0.3%
Medication Error	4A - Medication error (wrong route of administration)	2	0.3%
Medication Error	4A - Medication error (wrong time)	2	0.3%
Pregnancy	4D - Neonate low risk pregnancy delivery	2	0.3%
Intra- or Post-Operative Death	1E - Intra- or post-operative permanent harm	1	0.1%
Use of Contaminated	2A - Use of contaminated biolog(s)	1	0.1%
Device	2B - Device use other than intended	1	0.1%
Discharge	3A - Discharge or release of patient/resident unable to make decisions	1	0.1%
Medication Error	4A - Medication error (wrong patient)	1	0.1%
Pregnancy	4C - Maternal low risk pregnancy labor	1	0.1%
Failure to Communicate	4I - Failure to communicate (other)	1	0.1%
Restraint Related	5D - Use of Physical Restraint(s)	1	0.1%
Sexual Related	7C - Sexual abuse - attempted	1	0.1%
Physical Harm	7D - Homicide	1	0.1%
Total (Percentages may not add up to 100% due to rounding)		**748**	**100.0%**