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2025 Sentinel Events Registry Summary Report

Office of Analytics

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NEVADA HEALTH AUTHORITY

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NVHA.nv.gov

Agenda

- What is a Sentinel Event?
- Who Should Report a Sentinel Event?
- Why Investigate?
- Data collection methods
- Data and analysis results
- Plans and goals
- Conclusion

What is a Sentinel Event?

- Defined as a serious reportable event.
  - *Largely preventable, and harmful clinical events that should 'never' happen, resulting in a significant chance of an adverse outcome.*

- Reportable events are published by the National Quality Forum (NQF) (NRS 439.830).
  - *NQF adverse event definitions are updated periodically, necessitating periodic review by health care staff. Healthcare acquired infections no longer reported to State SER, but federally since 2013.*

- The terms 'sentinel event' and 'medical error' are not synonymous: not all sentinel events occur because of an error, and not all errors result in a sentinel event.

Who should report a Sentinel Event?

NRS 439.803 defines a “health facility” as:

1. Any facility licensed by the Health Care Purchasing and Compliance 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.

(Includes medical facilities)

Why Investigate?

Learning from mistakes is learning the hard way. By investigating mistakes, fewer future mistakes will be made.

Facilities need immediate investigation and response to gain the most improvement from an unfortunate outcome, and sentinel event reporting motivates that to some degree.

Investigation can result in new insights that can be a useful for quality of care and improved outcomes around patient safety and improvements in healthcare outcomes.

Performing a root cause analysis (RCA) can assist reporting facilities in both meeting sentinel event reporting requirements and identifying changes to improve quality of care.

Properly conducted investigations can result in more useful action plans designed to result in improvements to risk reduction. This includes means to monitor the effectiveness of those improvements.

Data Collection Methods

Using the Research Electronic Data Capture (REDCap) platform, reporting facilities' patient safety officers or their designated reporters can enter individual events, the annual summary report, and the facility's contact information.

Individual event report forms consist of:

- Part 1: Initial report to sentinel events registry (notification) — due 14 days from event awareness
- Part 2: Factor areas, departments, and root cause analysis findings — due 45 days after notification

Summary annual report forms (due March 1 for the previous calendar year) consist of :

- Summary annual report form
- Patient safety meeting activities
- Patient safety plan (medical facilities only)
- **All health facilities are required to submit regardless if any events occur.**

Standardized list of reportable events as selection criteria, including category for non-natural death.

Data and Analysis Results

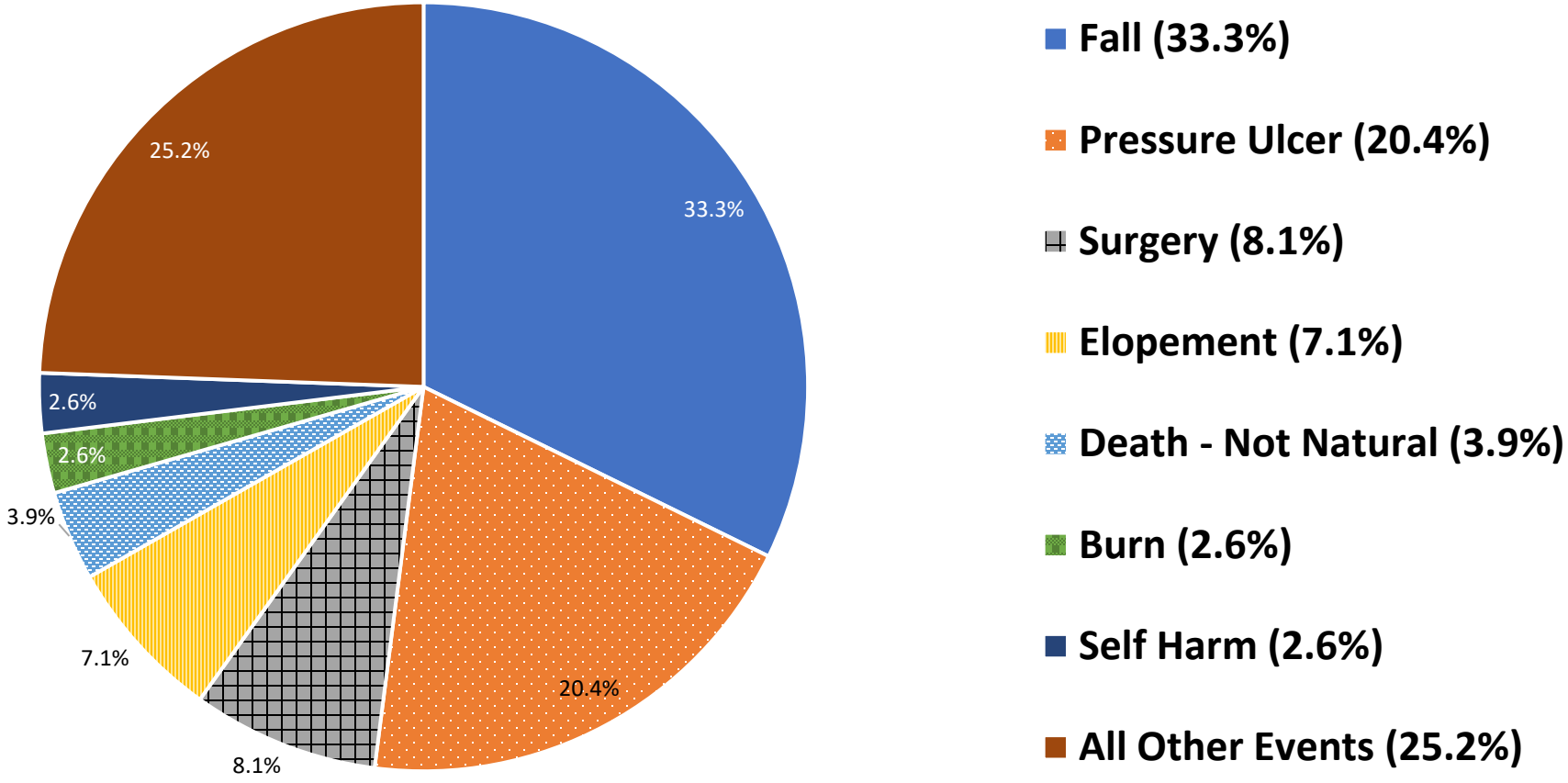
Sentinel Event Registry participation by health facility type

Participation Rates	2025	2024	2023	2022	2021
Participation Count of Facilities	309	239	230	199	142
Participation Percent of All Facilities	15.9%	12.1%	12.6%	11.2%	8.5%
Medical Facilities Count	51	50	53	50	54
Medical Facilities Percent	82.3%	69.4%	75.7%	68.5%	83.1%
Health Facilites Count	258	189	177	149	88
Health Facilities Percent	13.8%	9.9%	10.1%	8.8%	5.5%
Facility Count at least one event	65	73	69	59	56
Facility Count Filed Annual Report	294	224	214	190	128
Total Facility Count	1,938	1,980	1,823	1,769	1,676

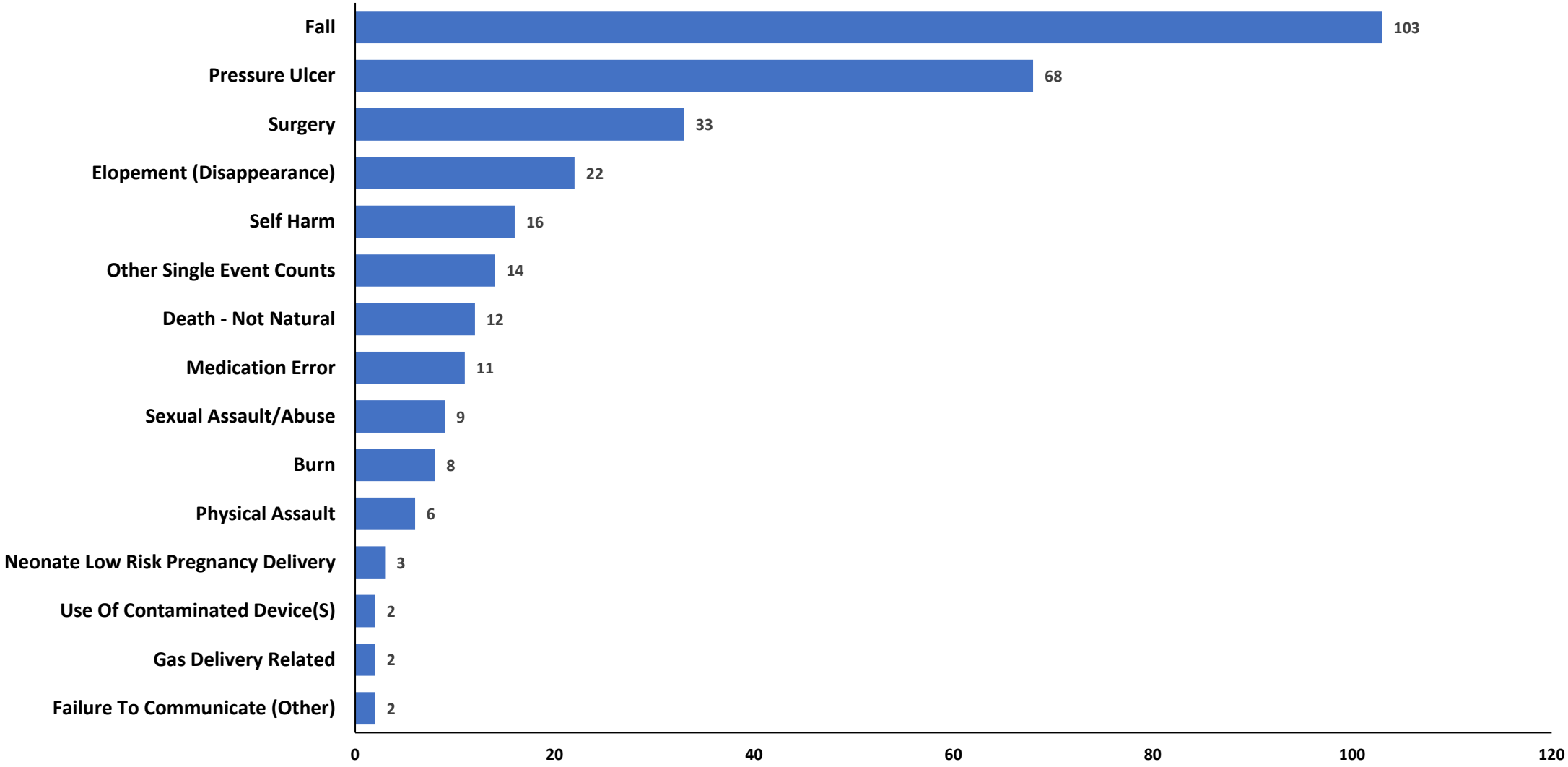
Key findings:

The SER findings for 2025 represent nearly 16%, an improvement from 12% of all the health facilities in Nevada from the previous year.

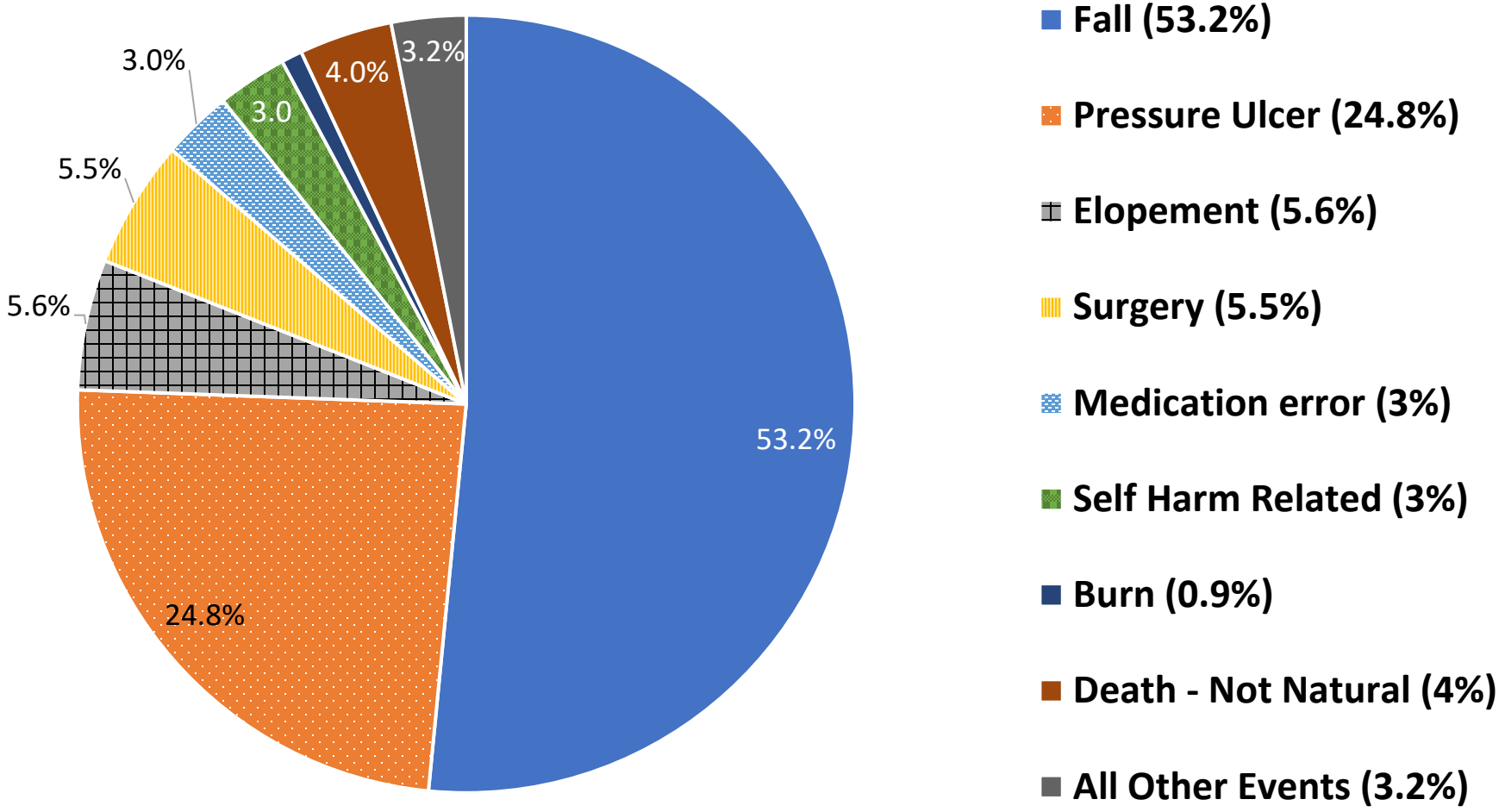
Types of Sentinel Events Reported in 2025



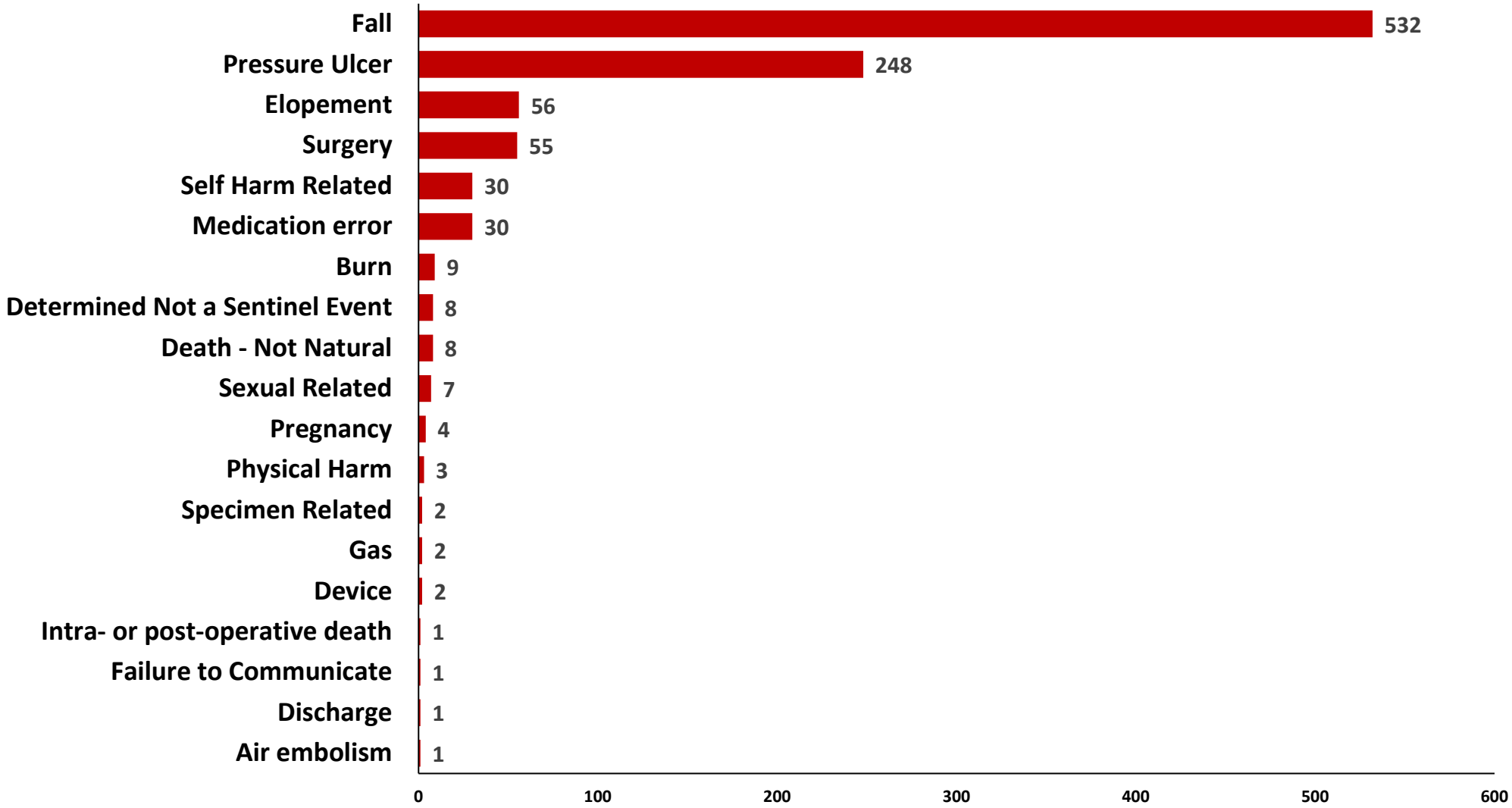
Individual Sentinel Events Reported in 2025



Sentinel Events from 2025 Annual Summary Report

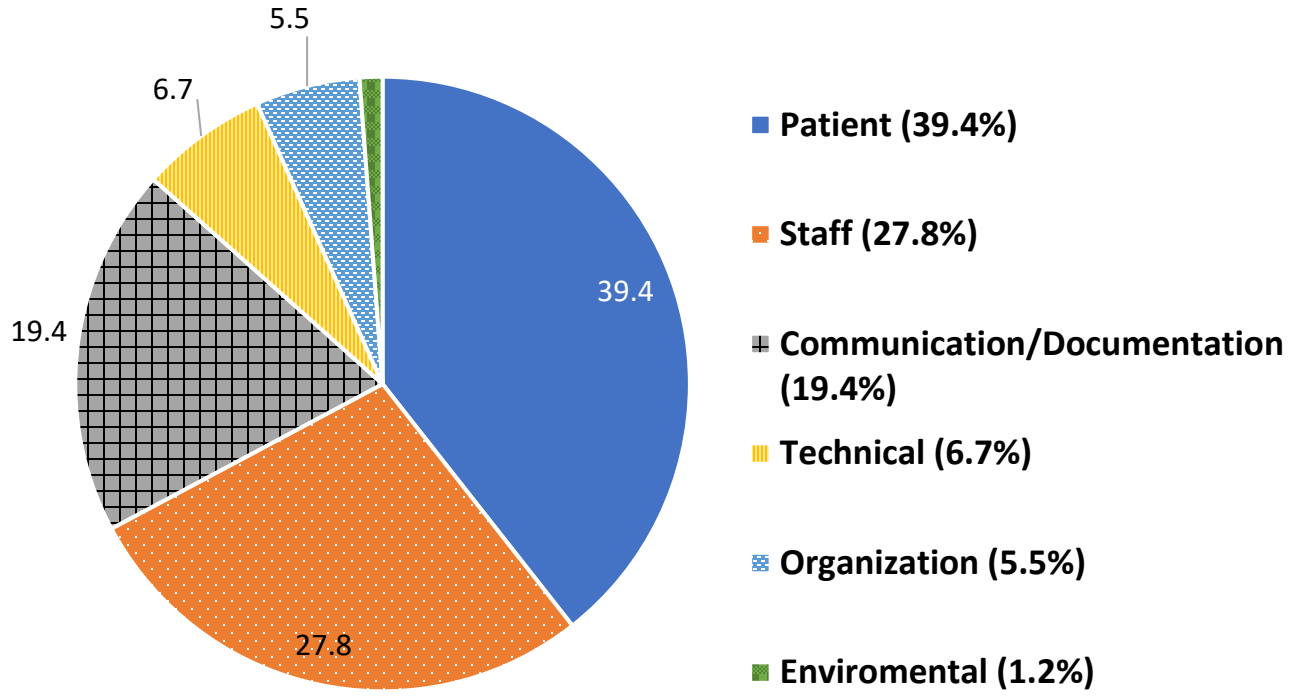


Sentinel Event Counts from 2025 Annual Summary Report



Factors Attributed

Contributing Factors to Events	%
Patient	39.4%
Staff	27.8%
Communication/documentation	19.4%
Technical	6.7%
Organization	5.5%
Environment	1.2%
Total	100%



In 2025, technical factors increased further relative to organizational factors

Safety Meetings

Facilities Meetings NRS Expectation Monthly (>25 employees and contractors) or Quarterly (<=25 employees and contractors)		
Meetings Per NRS Expectation	**Total Facilities**	**Percentage**
Yes	**219**	**74.5%**
No (Non-Compliant)	**70**	**23.8%**
Did Not Report	**5**	**1.7%**
Total	**207**	**100%**

Non-compliant facilities jumped from 16.1% in 2024 to 23.8%. Non-compliance can be not holding patient safety meetings, or holding patient safety meetings less frequently than NRS expectations.

SER Frequently Asked Questions

Sentinel Events Registry's FAQ

The FAQ Section Answers:

- What and How of the SER
- Minimum Expectations
- Timelines
- Report of adverse events, and submission of the annual summary report
- Instructions for Individual Report Events Part 1 and Part 2

SER Plans and Achievements

Plans:

- SER dashboard is in progress.
- Create a series of short instructional videos. Appropriate tools being accessed.
- Fully return all appropriate content to the program's website since the August 2025 State of Nevada network attack.

Achievements:

- Timely response to onboarding and help issues for facility representatives.
- Continue to maintain data quality processes.

SER Annual Report Conclusion

The Sentinel Events Registry focuses on helping licensed health facilities identify and report serious, preventable incidents. Every interaction seeks to raise patient safety awareness.

The program is proactive, and not punitive. The notification email this year mentioned financial penalties and may be responsible for the improvement in participation rates.

Reporting levels for the year 2025 were very similar to previous years, with some improvement. Issues that continue revolve around participation rates, training new Patient Safety Officers and Designated Reporters on how to meet programs expectations, and data collection improvements.

Improving patient safety is the responsibility of all stakeholders in the health care system: patients, providers, health professionals, organizations, and governments.

Questions?

Contact Information

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- https://www.dpbh.nv.gov/programs/office-of-state-epidemiology-ose/sentinel-events-registry-ser/

Sentinel Events Registry