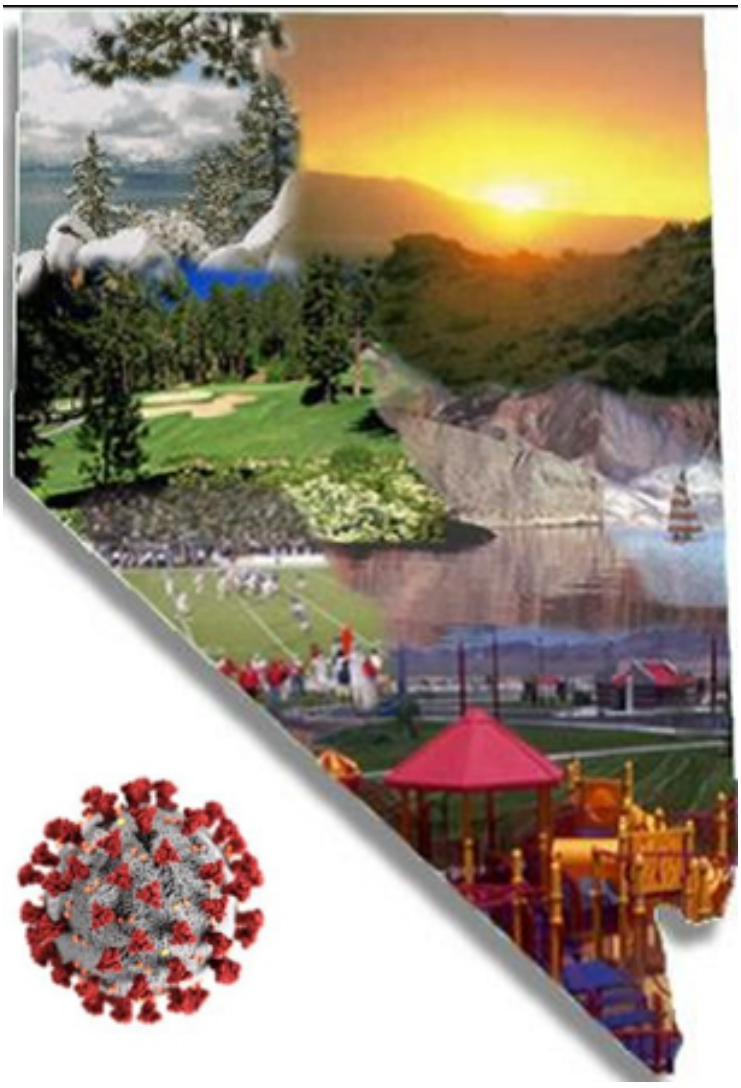
2020 Annual Sentinel Event Summary Report



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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 eleventh annual summary report compiled pursuant to Nevada Revised Statutes (NRS) **439.843**.

This report provides 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 better manage their health care decisions; 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 healthcare 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 2020. 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 – 80th Session

Senate Bill 457 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 DPBH. The legislation amended 449.803 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 439.835 requires that health facilities report sentinel events to DPBH. The SER database is administered by OPHIE. As specified in NRS 439.805, 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, page 1666)

SB457 notification was sent to the email on file with the DPBH's, Health Care Quality and Compliance (HCQC) license database (HCQC Licensing Information Website) informing 1,513 facilities of the new NRS affecting their health care facility (including those already required) on January 2, 2020. On January 2, 2021 a reminder email was sent to facilities that had yet to enroll in the SER based on the SB457 initial list. This email notification included a link to a sign-up survey, with 24 new facilities taking advantage of this opportunity. There are currently 1,772 facilities expected to participate. Since 2019, there are five new facility types that qualify for participation in the SER (see stared license type codes in table1). Since 2019, 40 facilities that had enrolled in the SER have since closed. The degree of participation achieved to date is shown in table 1.

Table 1: Healthcare facility type list and enrolled totals.

Facility Code	Facility Description Type	Percent SER Enrolled	Count of SER Enrolled	Count of Facility Type
HHA	AGENCY TO PROVIDE NURSING IN THE HOME	16%	30	191
HBR	AGENCY TO PROVIDE NURSING IN THE HOME - BRANCH OFFICE	0%	0	6
HSB	AGENCY TO PROVIDE NURSING IN THE HOME - SUB UNIT	0%	0	2
PCS	AGENCY TO PROVIDE PERSONAL CARE SERVICES IN THE HOME	16%	42	269
BPR	BUSINESS THAT PROVIDES REFERRALS TO RFFG OR OTHER APPLICABLE GROUP HOMES	0%	0	2
CBL*	COMMUNITY BASED LIVING ARRANGEMENT SERVICES - RESIDENTIAL CBLA FACILITY	0%	0	106
CBA*	COMMUNITY BASED LIVING ARRANGEMENT SERVICES - SERVICE ONLY PROVIDER	0%	0	4
CTC	COMMUNITY TRIAGE CENTER	33%	1	3
HFS	FACILITY FOR HOSPICE CARE	0%	0	3
ICF	FACILITY FOR INTERMEDIATE CARE	50%	2	4
IMR	FACILITY FOR INTERMEDIATE CARE/IID	0%	0	7
MDX	FACILITY FOR MODIFIED MEDICAL DETOXIFICATION	20%	1	5
SNF	FACILITY FOR SKILLED NURSING	29%	16	56
ADC	FACILITY FOR THE CARE OF ADULTS DURING THE DAY	19%	7	36

Facility Code	Facility Description Type	Percent SER Enrolled	Count of SER Enrolled	Count of Facility Type
ADA	FACILITY FOR THE TREATMENT OF ABUSE OF ALCOHOL OR DRUGS	29%	7	24
ESRD	FACILITY FOR THE TREATMENT OF IRREVERSIBLE RENAL DISEASE	61%	33	54
TLF	FACILITY FOR TRANSITIONAL LIVING OF RELEASED OFFENDERS	17%	1	6
NTC	FACILITY FOR TREATMENT WITH NARCOTICS	0%	0	16
HWH	HALF-WAY HOUSE FOR RECOVERING ALCOHOL AND DRUG ABUSERS	0%	0	7
HIC	HOME FOR INDIVIDUAL RESIDENTIAL CARE	10%	14	142
HPC	HOSPICE CARE - PROGRAM OF CARE	9%	9	105
HOS	HOSPITAL	94%	49	52
ICE	INDEPENDENT CENTER FOR EMERGENCY MEDICAL CARE	100%	1	1
ISO*	INTERMEDIARY SERVICE ORGANIZATION	0%	0	2
MED*	MEDICATION UNIT	0%	0	3
NSP	NURSING POOL	18%	10	57
OBC	OBSTETRIC CENTER	0%	0	1
OPF	OUTPATIENT FACILITY	23%	10	44
PCO	PERSONAL CARE AGENCY THAT IS ALSO ISO CERTIFIED	18%	3	17
DVP*	PROGRAM FOR TREATMENT OF PERSONS WHO COMMIT DOMESTIC VIOLENCE	0%	0	30
PRTF	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY	0%	0	12
AGC	RESIDENTIAL FACILITY FOR GROUPS	25%	95	384
RHC	RURAL CLINIC	0%	0	18
RUH	RURAL HOSPITAL	100%	14	14
SFD	SKILLED NURSING FACILITY DISTINCT PART OF HOSPITAL	0%	0	8
ASC	SURGICAL CENTER FOR AMBULATORY PATIENTS	89%	71	80
* New facility type for reporting, beginning CY 2020.				

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, page 3068**; and **2019, page 1667**)

REDCap(Research Electronic Data Capture Application – Vanderbilt University – CDC Grant funded) reporting forms were retooled to accommodate the SB457 program expansion. The basic REDCap data capture tool is called a project. The State of Nevada SER know uses three projects to input data,

1) SER457_EventReporting for entering events,
2) SER457_AnnualReport for entering the Annual Summary Report (ASRSER), and
3) SER457_Contacts for each facility to provide information about their facility and the staff authorized to report to the SER.

This change is different from the past, where the Annual Summary Report included the facility's contact forms.

The list of reportable events found in the two reporting tools had previously not offered the same set of choices. Standardizing the list of event types for both the event reporting and annual reporting options was completed. 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. The inclusion of voluntary reporting events will likely be discontinued.

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. Once submitted to the sentinel event database, the SER Registrar will review the record and mark the form record as 'Verified.' Or the SER Registrar will contact the reporting facility asking for clarification. 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). As of October 20, 2016, this system is located at **State of Nevada REDCap**. The

Sentinel Event Registrar (allocated at 20% of a full time equivalent 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.

The REDCap reporting system project, 'SER457_AnnualReport', contains the Annual Summary Report form. Each medical facility was to complete the online reporting requirement by March 1, 2021, for the calendar year 2020. 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 2020 calendar year reporting deadline has not been strictly enforced, nor have reminders been sent. The Registrar has not been available to conduct the facility liaison needed to reach optimum compliance.

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

All data reported reflects reporting during the calendar year, not the State physical 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 2020, 61 facilities reported sentinel events. A total of 307 sentinel event records were reported, grouped as follows:

- 271 events were true sentinel events per the current definition.
- 12 Deaths – Not Natural (SB457)
- 15 events were voluntary reporting related to HAI, and other adverse but not **NQF** events.
- 8 events reported were later deemed to not be **NQF** sentinel events.*
- 1 event has yet to have their event selection made by the facility.

* All pending event determinations from previous years have been resolved either by expiration of time, or by autopsy or laboratory testing or review of the record by licensed medical professionals.

Table 2: Sentinel event record classification, 2020.

Event Type	Count
Not a Sentinel Event	8
To be determined or event type selection pending	1
Is a Sentinel Event	271
Death – Not Natural	12
Voluntary reporting (HAI's, and other adverse but not NQF events)	15
Total Event Reports	**307**

Table 3: Sentinel event totals by facility type, 2020 (event reporting forms).

Facility Type Defined	Facility Type Code	Count Facilities Reporting	Count of Un-Natural Death	Count of Sentinel Events by Facility Type
FACILITY FOR MODIFIED MEDICAL DETOXIFICATION	MDX	1	1	0
AGENCY TO PROVIDE NURSING IN THE HOME	HHA	2	6	0
FACILITY FOR THE TREATMENT OF ABUSE OF ALCOHOL OR DRUGS	ADA	1	1	0
HOME FOR INDIVIDUAL RESIDENTIAL CARE	HIC	1	0	1
HOSPITAL	HOS	32	1	238
OUTPATIENT FACILITY	OPF	2	0	1
RESIDENTIAL FACILITY FOR GROUPS	AGC	4	0	5
RURAL HOSPITAL	RUH	8	2	16
SURGICAL CENTER FOR AMBULATORY PATIENTS	ASC	9	1	10
Total		**60**	**12**	**271**

Table 4: Sentinel event totals, 2020 (event reporting forms).

Rank	Category	NQF – Event	Count	Percent
1	Fall	4E – Fall	103	38.0%
2	Pressure Ulcer	4F - Pressure ulcer (stage 3 or 4 or unstageable)	95	35.1%
3	Surgery	1C - Procedure complication(s)	10	3.7%
4	Gas	5B - No gas from system designated for gas to be delivered	9	3.3%
5	Surgery	1D - Unintended retained foreign object	9	3.3%
6	Surgery	1A - Surgery (invasive procedure) on wrong site (body part)	6	2.2%
7	Physical Harm	7D - Physical Assault	6	2.2%
8	Elopement	3B - Elopement (disappearance)	6	2.2%
9	Pregnancy	4D - Neonate low risk pregnancy delivery	5	1.8%
10	Sexual-Related	7C - Sexual assault	2	0.7%
11	Burn	5C – Burn	2	0.7%
12	Self-Harm Related	3C - Suicide - attempted	2	0.7%
13	Failure to Communicate	4I - Failure to communicate laboratory test result	2	0.7%
14	Pregnancy	4D - Neonate low risk pregnancy labor	2	0.7%
15	Self-Harm Related	3C – Suicide	2	0.7%
16	Pregnancy	4C - Maternal low risk pregnancy intrapartum	1	0.4%
17	Intra- or post-operative death	1E - Intra- or post-operative death	1	0.4%
18	Air embolism	2C - Air embolism	1	0.4%
19	Self-Harm Related	3C - Self harm	1	0.4%
20	Medication- error	4A - Medication error (wrong drug)	1	0.4%
21	Medication- error	4A - Medication error (wrong route of administration)	1	0.4%
22	Medication- error	4A - Medication error (wrong time)	1	0.4%
23	Failure to Communicate	4I - Failure to communicate radiology test result	1	0.4%
24	Pressure Ulcer	4F - Pressure ulcer (stage 3 or 4 or unstageable) with HAI	1	0.4%
25	Specimen- Related	4H - Specimen ID Error	1	0.4%
		Total NQF events reported	**271**	**100%**
Not NQF		Not a Natural Death	12	
Not NQF		Voluntary for research HAI Other - specify	10	
Not NQF		Voluntary for research Treatment delay	5	
		Determined Not a Sentinel Event	10	
		To Be Determined	1	
		Total events reported of all types	**307**	

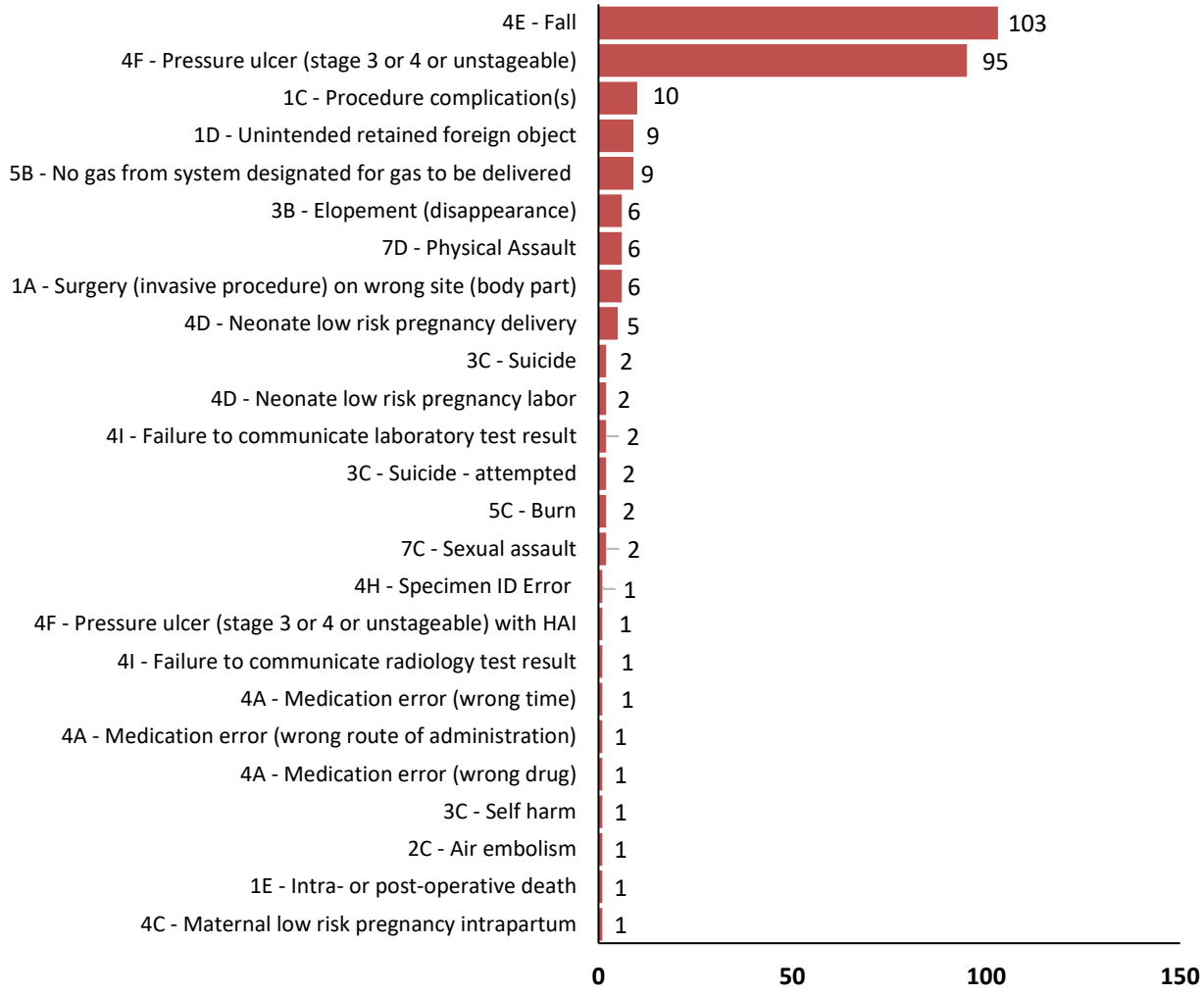

Figure 1: Sentinel event type counts, 2020.

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 2020 there were 416 enrolled facilities that were expected to file. A total of 83 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 (46%). There were 333 facilities that had not filed their

ASRSER (80%). The end of the business day on March 1, 2021 (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 thereafter. As of May 15, 2021, of all the facilities that started completing the annual summary form, several have not uploaded a patient safety plan or failed to enter all expected fields. This is a proactive, iterative (meaning repeated) dialog process between the SER Registrar and the contacts at the facilities, especially when meeting timeliness of reporting.

Table 5: Annual summary report record classification, 2020.

Event Type	Count in CY 2019
Facility Reported No Sentinel Events	39
Facility Reported One Sentinel Event	9
Facility Reported More than One Sentinel Events	37
Total Facilities Reporting to the Annual Report	83

These reporting healthcare facility types listed by their code and definition included the following:

Table 6: Annual summary report facility types and event totals, 2020.

Facility Type Code	Facility Type Defined	Count of Facility Type	Count of Sentinel Events	Count of All Events*
AGC	RESIDENTIAL FACILITY FOR GROUPS	14	106	106
ASC	SURGICAL CENTER FOR AMBULATORY PATIENTS	19	10	12
HHA	AGENCY TO PROVIDE NURSING IN THE HOME	2	0	0
HIC	HOME FOR INDIVIDUAL RESIDENTIAL CARE	1	1	1
HOS	HOSPITAL	30	189	213
HPC	HOSPICE CARE - PROGRAM OF CARE	1	0	0
MDX	FACILITY FOR MODIFIED MEDICAL DETOXIFICATION	1	0	0
NSP	NURSING POOL	1	0	0
OPF	OUTPATIENT FACILITY	3	2	2
PCO	PERSONAL CARE AGENCY THAT IS ALSO ISO CERTIFIED	1	4	4
PCS	AGENCY TO PROVIDE PERSONAL CARE SERVICES IN THE HOME	2	15	15
RUH	RURAL HOSPITAL**	7	13	15
SNF	FACILITY FOR SKILLED NURSING	1	0	0
ALL	**Count of facilities and events**	**83**	**340**	**368**

*** includes Sentinel Events, Un-Natural-Deaths and volunteer categories.**
*** plus 2 records not completed.**

Table 7 lists the types of sentinel events reportable with a total for each event, as indicated on the medical facilities' ASRSER. A percentage of all sentinel events reported is provided for each event type. In 2020, the medical facilities reported a total of 340 sentinel events (**NQF**) out of 368, non-natural death and voluntary events reported on this form.

Table 7: Sentinel event type totals, 2020 (annual summary forms).

Rank	Category	NQF – Event	Count	Percent
1	Fall	4E - Fall	196	57.3%
2	Pressure Ulcer	4F - Pressure ulcer (stage 3 or 4 or unstageable)	82	24.0%
3	Pressure Ulcer	4F - Pressure ulcer (stage 3 or 4 or unstageable) with HAI	12	3.5%
3	Medication-Error	4A - Medication error (wrong time)	7	2.0%
4	Surgery	1D - Unintended retained foreign object	6	1.8%
6	Elopement	3B - Elopement (disappearance)	5	1.5%
7	Surgery	1A - Surgery (invasive procedure) on wrong site (body part)	4	1.2%
8	Pregnancy	4D - Neonate low risk pregnancy delivery	4	1.2%
9	Surgery	1C - Procedure complication(s)	3	0.9%
10	Burn	5C - Burn	3	0.9%
11	Physical-Harm	7D - Physical Assault	3	0.9%
12	Failure to Communicate	4I - Failure to communicate radiology test result	2	0.6%
13	Sexual-Related	7C - Sexual assault	2	0.6%
14	Air Embolism	2C - Air embolism	1	0.3%
15	Discharge	3A - Discharge or release of patient/resident unable to make decisions	1	0.3%
16	Self-Harm Related	3C - Self harm	1	0.3%
17	Self-Harm Related	3C - Suicide - attempted	1	0.3%

Rank	Category	NQF – Event	Count	Percent
18	Medication-Error	4A - Medication error (wrong dose)	1	0.3%
19	Medication-Error	4A - Medication error (wrong drug)	1	0.3%
20	Pregnancy	4C - Maternal low risk pregnancy intrapartum	1	0.3%
21	Pregnancy	4D - Neonate low risk pregnancy labor	1	0.3%
22	Failure to Communicate	4I - Failure to communicate laboratory test result	1	0.3%
23	Gas	5B - No gas from system designated for gas to be delivered	1	0.3%
24	Sexual-Related	7C - Sexual assault - attempted	1	0.3%
		Total National Quality Foundation(NQF) events reported	**340**	**100%**
	Death	8 - Death - Other than Natural Causes (SB457)	2	
		Voluntary for research HAI Other - specify	26	
		Voluntary for research treatment delay	0	
		Total events reported of all types	**368**	

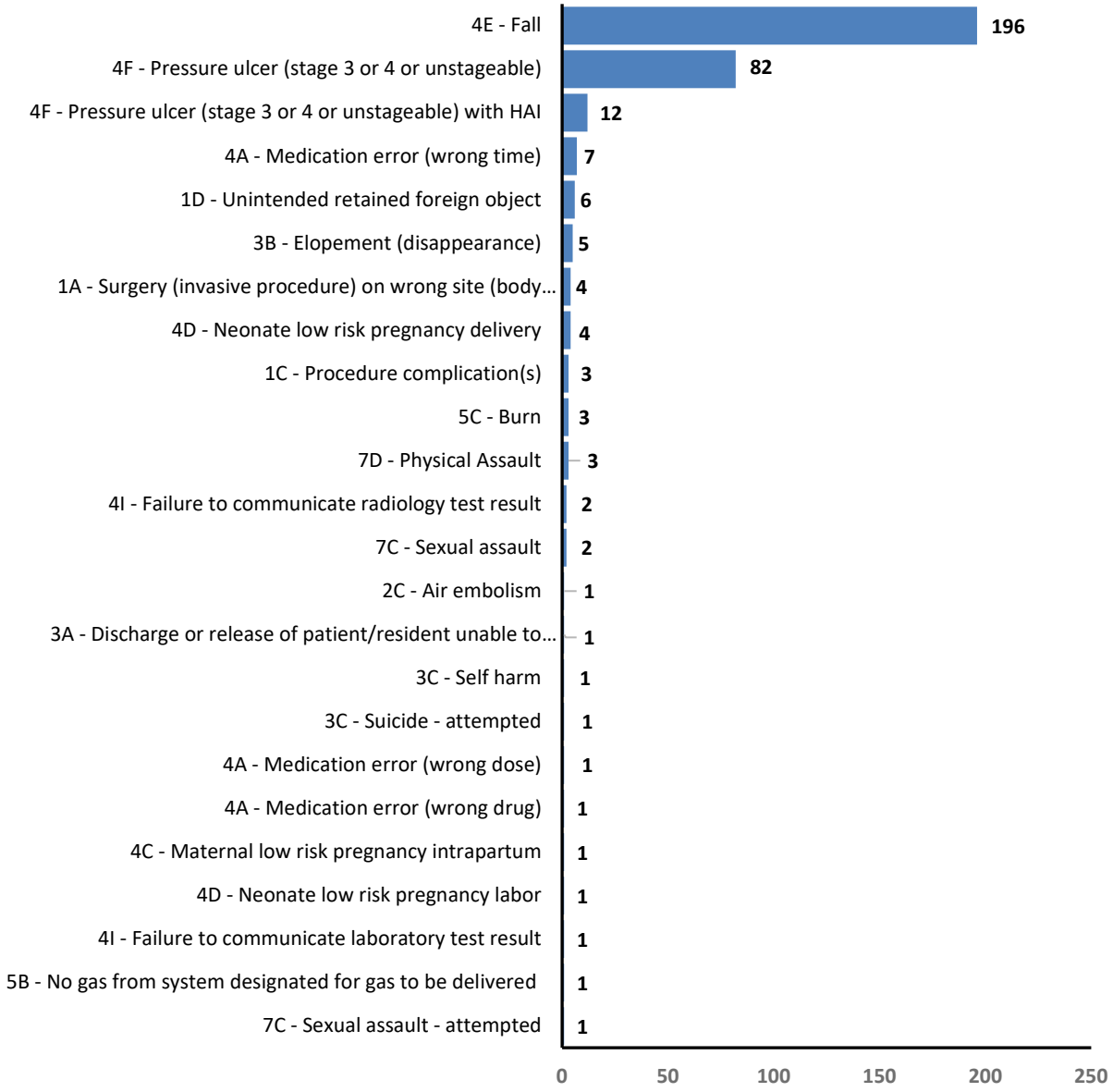

Figure 2: Sentinel event type totals, 2020 (annual summary forms).

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 (SER) individual incident reporting, and then compares the event types to data from the annual summary sentinel events reporting (ASRSER).

Event Totals

Table 8 lists the types of sentinel events reported, including totals of the numbers reported according to both the summary forms and the reports recorded in the SER. In 2020, a total of 340 sentinel events were reported according to the summary forms versus 271 as recorded in the SER, the comparison between reporting methods for 2020 differ by about nearly 23%, a higher than average difference, and higher than any of the previous five years. . 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.

Table 8: Total events, summary vs. registry (2016-2020).

Year	2016	2017	2018	2019	2020
Not Sentinel Events*	12	2	0	2	8
Registry Sentinel Events	323	277	262	306	271
Summary Sentinel Events	337	273	301	279	340
Difference	-14	4	-39	27	69
Difference Percent	-4.3%	1.4%	-14.9%	8.8%	-22.6%

Total Sentinel Events Summary Data vs. Registry Data (2016-2020)

From figure 3, illustrates the differences each year, over the last five years. There appears to be no underlying trend. Yet some explanation can be attributed to the level of system stress, i.e. in those years with more stress, the discrepancy is larger.

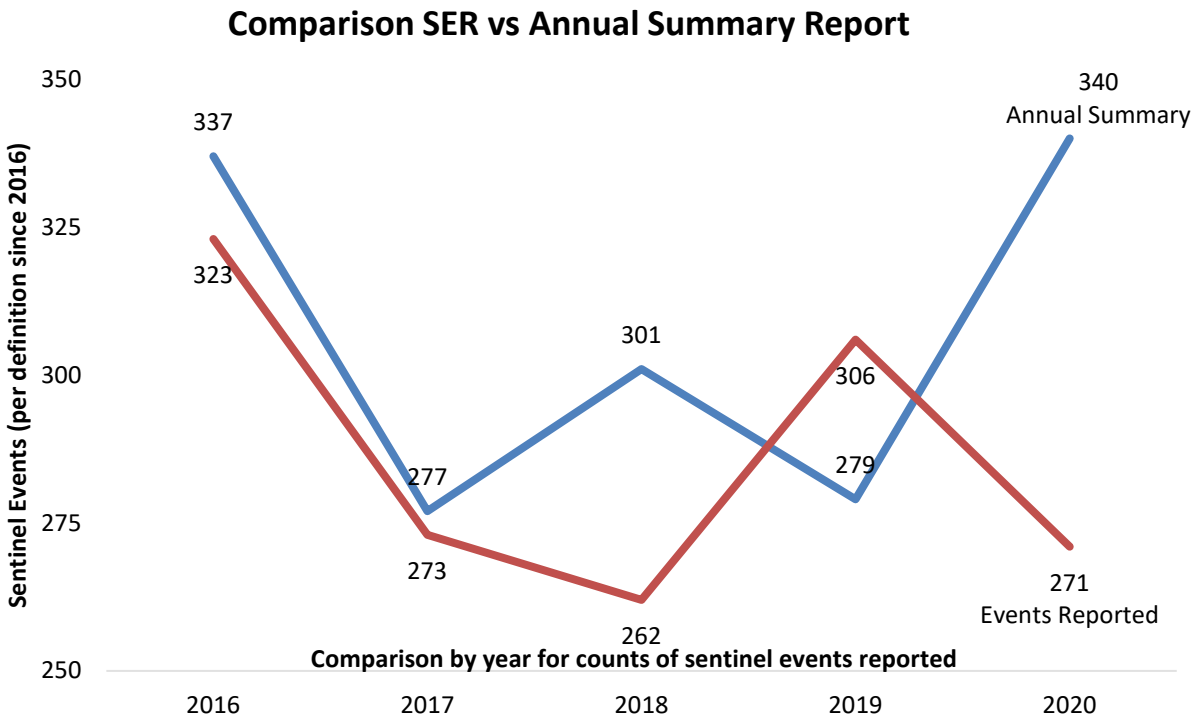

Figure 3: Total events, summary vs. registry (2016-2020).

Table 9: Sentinel event category totals annual summary vs registry events (2016-2020).

Description of Category * Description of Category *	2016		2017		2018		2019		2020	
	SER	ASR	SER	ASR	SER	ASR	SER	ASR	SER	ASR
Abduction	0	1	0	0	0	0	0	1	0	0
Air Embolism	0	0	0	0	0	0	0	0	1	1
Assisted Reproduction	0	0	0	0	0	0	0	0	0	0
Blood	0	0	1	1	0	0	0	0	0	0
Burn	2	8	7	13	2	9	5	4	2	3
Device	1	6	1	1	3	3	0	0	0	0
Discharge	0	0	2	3	0	1	0	0	0	1
Electrical	0	0	0	0	0	0	0	0	0	0

Description of Category * Description of Category *	2016		2017		2018		2019		2020	
	SER	ASR	SER	ASR	SER	ASR	SER	ASR	SER	ASR
Elopement	0	4	5	8	1	2	4	3	6	4
Failure to Communicate	0	5	0	1	0	2	2	3	3	3
Fall	13	132	59	113	57	96	116	117	103	195
Gas	0	1	0	0	1	1	1	1	9	1
Impersonation	0	0	0	0	0	0	0	0	0	0
Intra- or post-operative death	0	3	1	2	0	1	2	4	1	0
Medication-Error	1	7	4	54	2	25	6	15	3	9
MRI-Related	0	0	0	0	0	0	0	0	0	0
Physical-Harm	2	10	0	2	1	2	3	2	6	3
Pregnancy	1	9	1	6	0	1	5	5	8	6
Pressure Ulcer	7	91	29	58	49	99	98	89	96	94
Restraint-Related	1	3	0	0	0	1	2	2	0	0
Self-Harm Related	0	7	3	7	4	5	7	5	5	2
Sexual-Related	1	8	3	6	3	4	5	3	2	3
Specimen-Related	0	1	0	0	0	0	1	1	1	0
Surgery	2	31	14	31	20	31	43	36	25	13
Use of Contaminated	2	3	0	1	1	6	3	3	0	0

Primary Contributing Factors in 2020

For each sentinel event, a maximum of four (4) contributing factors may be entered. In 2020, there were 477 primary factors that contributed to sentinel events, which are grouped into the following factor areas; patient-related, staff-related, communication/documentation, organization, technical, environment, and other. Table 10 and Figure 4 show the top three contributing factor areas as:

- Patient related: 170 (38%)
- Staff related: 120 (27%)
- Communication/documentation: 101 (17%)

These three (3) factor aras constitute greater than 82% of the total primary contributing factor groups in 2020. On a percentage basis, Organization and Technical areas increased and Staff decreased slightly.

Table 10: Primary contributing factor areas (2016 to 2020).

Factor Area	2016 count	2016 %	2017 count	2017 %	2018 count	2018 %	2019 count	2019 %	2020 count	2020 %
Patient	352	42.4%	284	41.9%	222	32.3%	286	36.6%	170	38.3%
Staff	209	25.2%	206	29.8%	252	36.6%	266	34%	120	27%
Organization	36	4.3%	14	2.1%	19	2.8%	46	5.9%	37	8.3%
Environment	8	1.0%	9	1.3%	5	0.7%	6	0.8%	6	1.4%
Communication/Documentation	158	19%	113	16.9%	107	15.6%	135	17.3%	101	22.7%
Technical	68	8.2%	51	5%	83	12.1%	43	5.5%	43	2.3%
SUM	**831**		**677**		**688**		**782**	**100.0**	**477**	**100%**

Note: Each event can list up to four (4) factors.

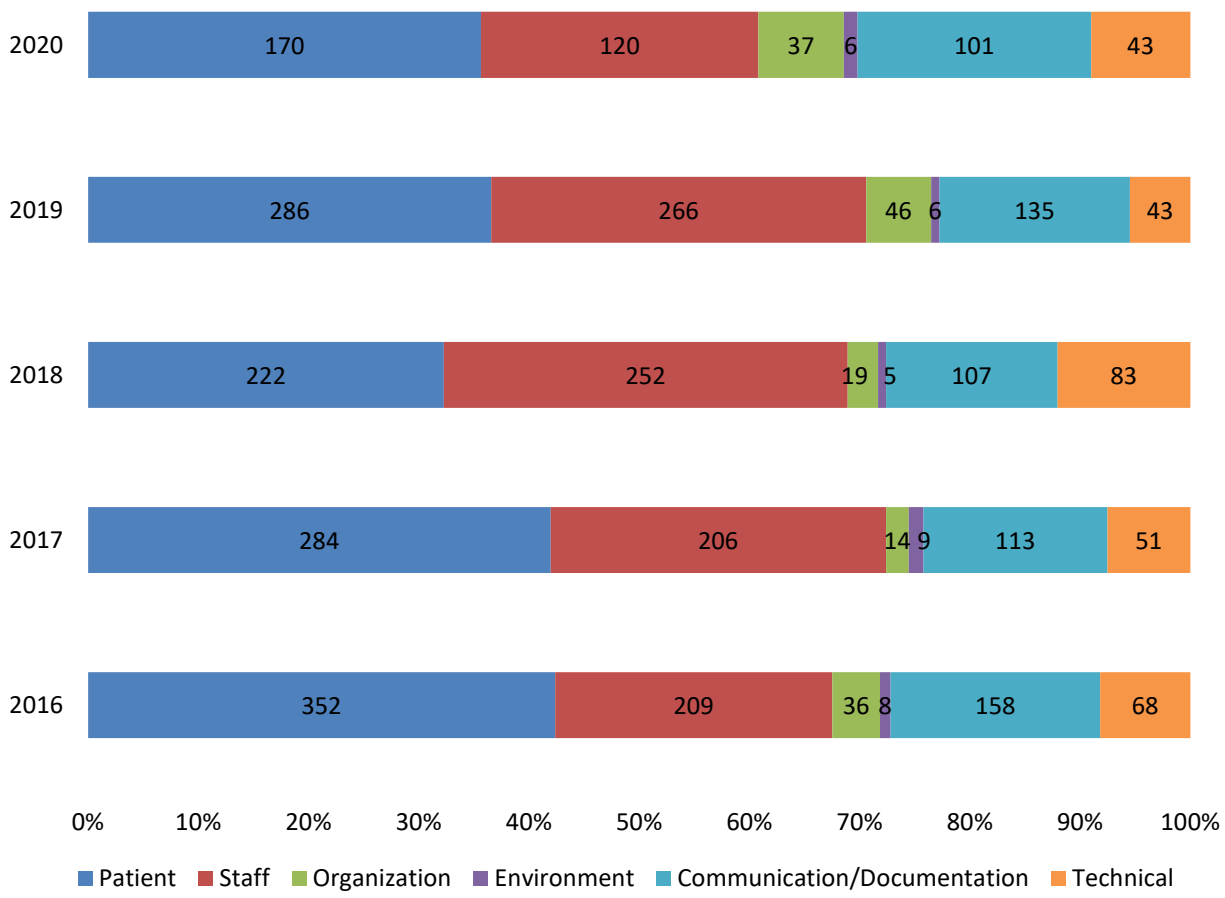

Figure 4: Primary contributing factor areas relative comparison (2016-2020).

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/or second. Technical issues appear to be increasing and have done so in the past. Communication and documentation have decreased slightly. Organization issues and environment issues remain relatively less of a factor area, as in previous years.

Detailed Primary Contributing Factors in 2020

The single most often cited contributing factor for 2020 was "Staff - Failure to follow policy and/or procedure."

Within the primary factor group areas there are many sub areas, referred to as 'detailed primary factors.' The detailed primary contributing factors in 2020 are displayed in Table 11. In 2020 Staff Failure Follow Policy or Procedure had 49 mentions, followed by Staff – Clinical Decision Assessment had

44 mentions, together accounting for nearly 20% of all detailed factors. Patient – Frail Unsteady, Patient – Physical Impairment and Patient – Physical Confusion were included in the top five (5), accounting for an additional nearly 27% of all detailed factors. These specific detailed factors consistently rank in the top five (5), suggesting areas that could benefit from additional safety focused attention. There were similar relationships reported with Patient Confusion replacing Staff Clinical Performance Administration in the top 5 for 2019. 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. 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 11: Detail of primary contributing factors, 2020.

Factors (up to 4 per event can be selected)	Counts	Percent
Staff-Related Failure to follow policy and/or procedure	49	11.0%
Staff-Related Clinical decision/assessment	44	9.9%
Patient-Related Frail/unsteady	43	9.7%
Patient-Related Physical Impairment	38	8.6%
Patient-Related Confusion	36	8.1%
Patient-Related Non-compliant	30	6.8%
Communication/Documentation Hand-off/teamwork/cross-coverage	28	6.3%
Staff-Related Clinical performance/administration	25	5.6%
Communication/Documentation Lack of communication	24	5.4%
Communication/Documentation Verbal communication-inadequate	21	4.7%
Communication/Documentation Lack of/inadequate documentation	20	4.5%
Organization Training inadequate/not done	17	3.8%
Patient-Related Medicated	11	2.5%

Factors (up to 4 per event can be selected)	Counts	Percent
Organization Culture-principles, ethics, values	7	1.6%
Organization Inappropriate/no policy/process	7	1.6%
Organization Staffing level	6	1.4%
Communication/Documentation Written communication-inadequate	4	0.9%
Technical Other	4	0.9%
Patient-Related Language barrier	3	0.7%
Patient-Related Psychosis	3	0.7%
Patient-Related Line/catheter/endotracheal tube removed	2	0.5%
Patient-Related Self-harm	2	0.5%
Environment emergency situation-internal	2	0.5%
Communication/Documentation Verbal communication-incorrect	2	0.5%
Patient-Related Allergy-known	1	0.2%
Patient-Related Allergy-unknown	1	0.2%
Staff-Related Patient identification	1	0.2%
Staff-Related Working outside scope of practice	1	0.2%
Environment Emergency situation-external	1	0.2%
Environment Lighting problem	1	0.2%
Environment Noise level	1	0.2%
Environment Wet/slippery floor/surface	1	0.2%
Communication/Documentation Abbreviation(s)	1	0.2%
Communication/Documentation Medical record-incorrect	1	0.2%

Factors (up to 4 per event can be selected)		Counts	Percent
Technical	Equipment-failure(s)	1	0.2%
Technical	Equipment-unavailable	1	0.2%
Technical	Omission	1	0.2%
Technical	Supplies-incorrect	1	0.2%
Technical	Test results-unavailable	1	0.2%
Technical	Treatment delay	1	0.2%
Total (detailed primary factors)		**444**	**100%**

Top 5 Contributing Factors in 2020, compared to the prior 5 years

Table 12 and Figure 5 show the top five (5) contributing factors in 2020 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 12: The top 5 primary contributing factors (2016-2020).

Year	STAFF Failure to Follow Policy	STAFF Clinical Decision Assessment	PATIENT Frail Unsteady	PATIENT Impairment Physical	PATIENT Confusion
2020	49	44	43	38	38
2019	97	92	74	70	45
2018	81	99	58	56	35
2017	76	82	62	56	41
2016	76	93	88	82	46

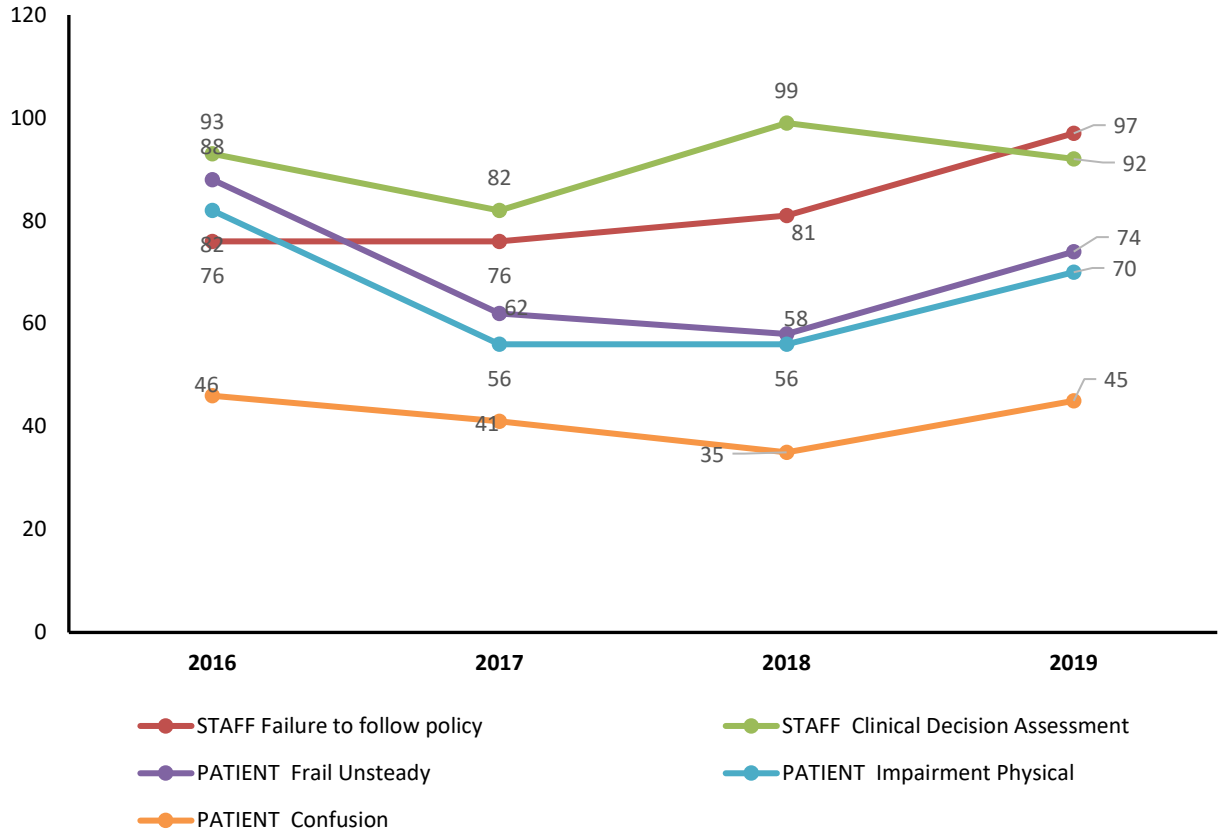

Figure 5: The top 5 primary contributing factors (2016-2020).

A few selected excerpts from the form field "Lessons Learned"

A field was added to the event form part2 asking for 'Lessons Learned" since last year's reporting. In order to give voice to the practical knowledge gleaned from the root-cause-analysis process, the following comments are provided:

"…lack of team work between staff…"

"…documentation lacking… … do not use illegible abbreviations…"

"…patient bed alarm was not used…"

"…during shift change huddle abnormal observations where not passed on…"

“In a fast paced, repetitive service line, it's imperative to provide recurring training on distraction free activities. Secondly, the need to provide training for all staff ... to include the professional staff on the responsibilities of critical tasks.”

“…evaluate medication reactions sooner and more often…”

“…Failure to adhere to policy/procedure. Failure to communicate appropriately among staff members.”

"Unit where everyone was considered a fall risk, this caused lack of heightened awareness… "

"-ACCOUNTING for sponges -Education/Training -Standardize all ORs "

Distribution of Sentinel Events by Facility Type in 2020

The following counts illustrate reporting rates, diligence in reporting sentinel events, patient/client volumes and facility safety attitudes. High numbers do not necessarily reflect deficiencies in patient safety.

Table 13: Sentinel event totals by enrolled facility types, 2020.

Facility Code	Total Enrolled	Did Not Report	0	1	2	3	4	5	6-9	10-30	>30
ADA	7	7									
ADC	8	8									
AGC	111	97	8	1	1		1			2	1
ASC	72	53	13	3	1	1	1				
CTC	1	1									
ESRD	33	33									
HFS	1	1									
HHA	31	29	2								
HIC	18	17		1							
HOS	55	25	7	2	2	3	1	1	5	9	
HPC	10	9	1								
ICE	1	1									
ICF	2	2									
MDX	2	1	1								

Facility Code	Total Enrolled	Did Not Report	0	1	2	3	4	5	6-9	10-30	>30
NSP	11	10	1								
OPF	11	8	1	2							
PCO	3	2					1				
PCS	47	45	1							1	
RUH	13	6	2		3	1	1				
SNF	16	15	1								
TLF	1	1									
Total	**454**	**371**	**38**	**9**	**7**	**5**	**5**	**1**	**5**	**12**	**1**

Sentinel Events by Age in 2020

Age bin counts reflect the fact that the risk of a fall increases with age. For younger age groups, the very young showed an outlier, suggesting heightened vulnerability.

Table 14: Sentinel events by age, 2020 (event reporting).

Patient's Age	Count	Percent
<1 year old	10	3.8%
1-9 years old	0	0.0%
10-19 years old	6	2.3%
20-29 years old	5	1.9%
30-39 years old	11	4.2%
40-49 years old	17	6.4%
50-59 years old	44	16.6%
60-69 years old	64	24.2%
70-79 years old	56	21.1%
80-89 years old	40	15.1%
90-99 years old	12	4.5%
100+ years old	0	0.0%
Total (excludes bad data)	**265**	(May not equal 100% due to rounding.) **100%**

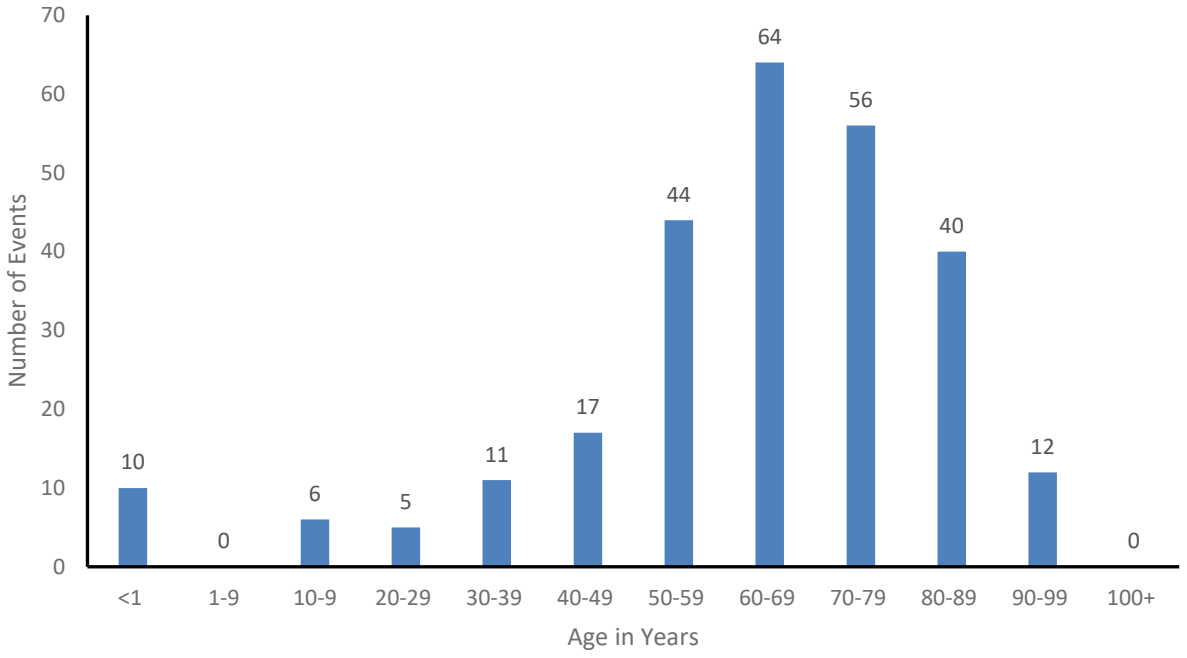

Figure 6: Sentinel Events by age, 2020 (event reporting).

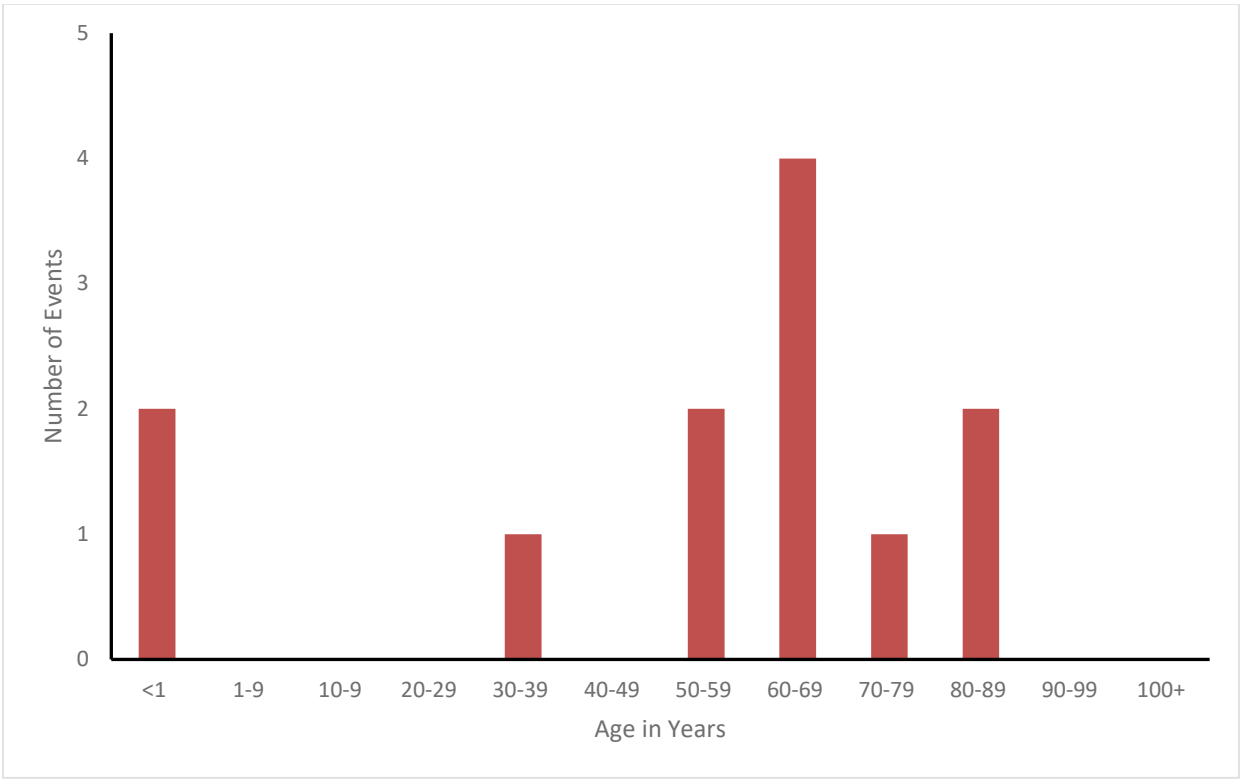

Figure 7: Un-Natural-Deaths by age, 2020 (event reporting).

Sentinel Events in relation to total patient discharges

The events covered in this report are relatively rare. Putting a number to the risk offers a concrete way of looking at the chance that your net visit to a healthcare facility includes an adverse outcome. 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, a likelihood that you experience an adverse event.

The update to this metric is suspended currently, due to COVID-19 issues impacting access to data.

This metric is available only for Hospitals, and Ambulatory Surgery Centers, due to limited patient traffic data sources available. The most recent previous statewide average was 0.000645 adverse outcomes per discharge (2018).

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) of an event 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 2020, 226 (84%) events were informed to the SER within the expected 14 days. In 2019, 285 (99.7%) events were informed to the SER within the expected 14 days than in 2020. In 2018, 75%, in 2017, 74% reported within the expected 14 days. Many of the events with data issues did not meet notification timelines.

Table 15: Duration between event aware date and the state notification date (2016-2020).

Duration	2016	2017	2018	2019	2020	Percent of Events
0-14 days	275	213	196	285	226	83.7%
15-30 days	28	29	33	1	31	11.5%
31-60 days	9	20	13	0	9	3.3%
61-90 days	6	9	5	0	3	1.1%
91-120 days	3	2	7	0	0	0.0%
120+ days	1	4	8	0	1	0.4%
Bad Data (excluded from totals)				22	1	
Total	**322**	**277**	**262**	**286**	**270***	**100%**
*plus the 1 bad data point in relation to this metric, equals 271						

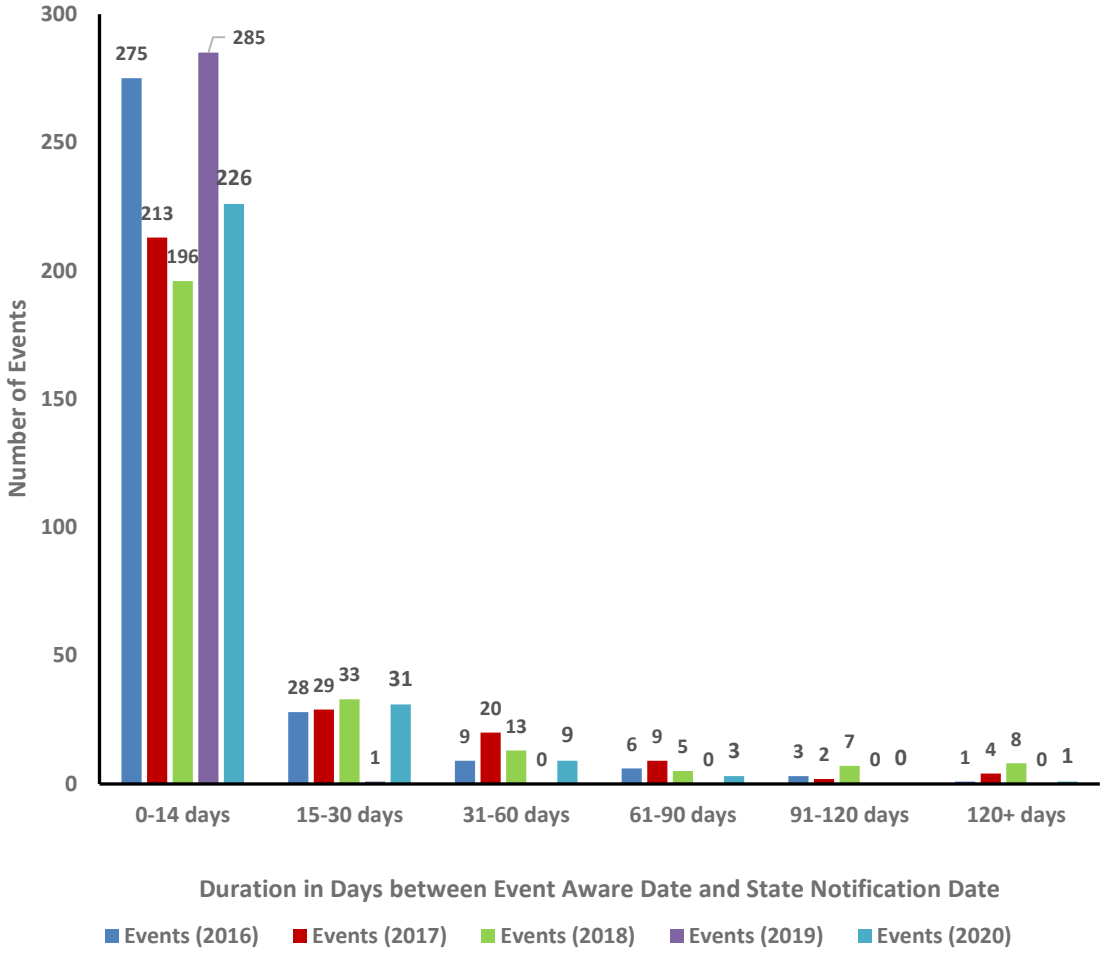

Figure 8: Duration between event aware date and the State notification Date (2016 – 2020).

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 as mentioned previously. 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 16 and Figure 9 illustrate that in 2020, close to 73% met the requirements. In comparison, nearly 83% may have indicated a pre-pandemic diligence to meeting reporting expectations in 2019. While in 2018 just over 93%, 92 in 2017%, and 97% in 2016 reported within the expected timeline. Forty-two (42) events are categorized as "Unknown" since there are date errors associated with those records, and likely reflects pandemic conditions.

Table 16: Duration in days between SER part 1 form and SER part 2 form (2016-2020).

Days between Part 1 and Part 2 SER Report Submission	2016	2017	2018	2019	2020	Percent-2020
0-45 days	314	255	245	253	199	73.40
46-60 days	7	5	7	13	8	3.0%
61-90 days	0	5	3	6	11	4.1%
91-120 days	1	0	0	3	3	1.1%
120+ days	0	0	1	14	8	3.0%
Unknown (bad data)	2	12	6	17	42	15.5%
Total Events	**324**	**277**	**262**	**306**	**271**	**100%**

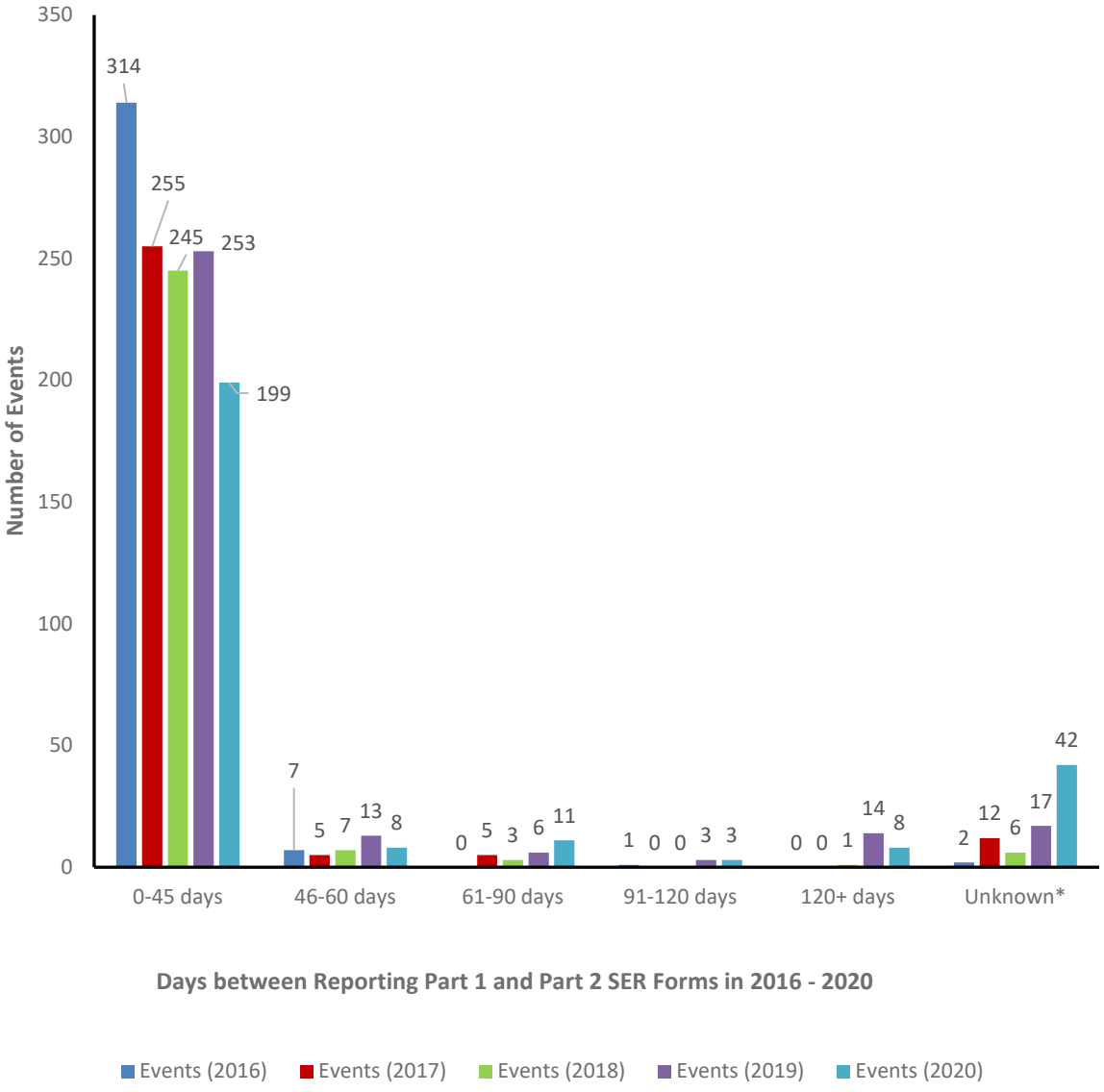

Figure 9: Duration in days between SER part 1 form and SER part 2 form (2016-2020).

Days Between Event-Aware and Patient-Notification and the Notification Methods

Patients affected by approximately 59% of the events were notified within one day as long as the facilities were aware of the occurrence of the sentinel events. The predominant notification methods are telling the patient in person (116, 43%) or over the telephone (58, 21%).

Table 17: Duration in days between Event Aware and the patient notification date, 2020.

Duration (days)	Events	Percent
<1	162	59.8%
1 - 2	17	6.3%
3 - 5	7	2.6%
6 - 8	2	0.7%
8+	1	0.4%
Bad Date	43	15.9%
Not Notified	39	14.4%
Totals	**271**	**100%**

Table 18: Method of notification to the patient, 2020.

Notification methods	Events	Percent
Told in Person	116	42.8%
Telephone	58	21.4%
Not Notified	39	14.4%
Email / US Mail	1	0.4%
Hand-Delivered Message	0	0.0%
No Data or No Next of Kin	57	21.0%
Total	**271**	**100%**

Sentinel Events by Month in 2020

Table 19 and Figure 10 indicate that February was the peak month of occurrence in 2020, while August was the peak month for sentinel event counts in 2019 (January for 2018, November for 2017, and August in 2016). October was the month with the lowest number of reported events.

Table 19: Sentinel events by month (2016-2020, event reporting).

Month	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
2020	25	30	28	17	19	24	23	26	23	14	18	24
2019	34	24	19	25	26	34	17	36	19	20	29	23
2018	34	26	24	12	21	24	11	25	15	27	23	20
2017	25	26	24	21	22	16	18	17	25	21	33	22
2016	31	27	31	29	31	25	22	33	26	18	24	27
Mean	29.8	26.6	25.4	21.2	23.8	24.6	18.4	27.2	21.6	19.8	25.4	23.4

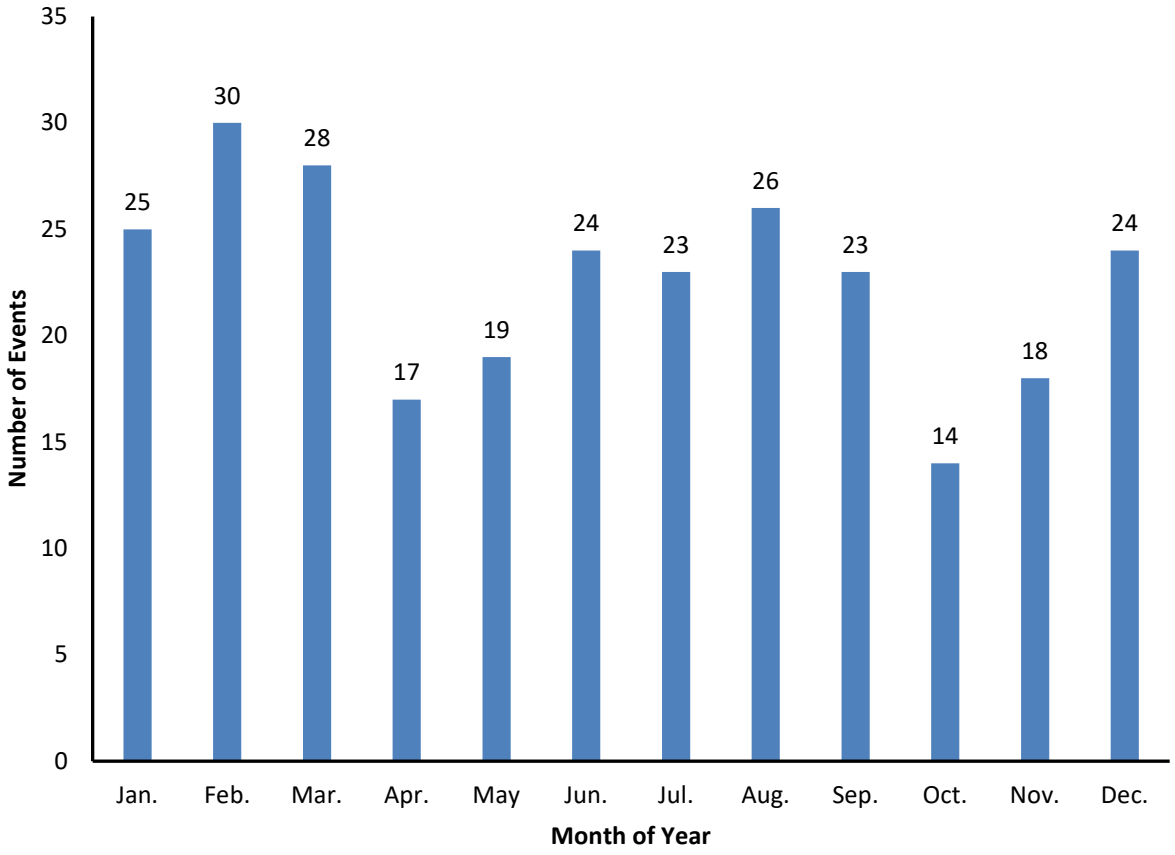

Figure 10: Sentinel events by month, 2020 (event reporting).

Sentinel Events by Day-Of-Week in 2020

The inclusion of the day of the week offers some area for pro-active efforts towards safety on those days of the week known to have a higher likelihood of an adverse outcome.

Table 20: Sentinel events by day of week, 2020 (event reporting).

Day of Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2020	47	53	56	37	33	27	18
2019	62	59	48	48	36	22	31
2018	54	46	44	39	37	23	22
2017	40	42	50	41	42	26	29
2016	37	52	57	52	49	37	34
Mean	48	50.4	51	43.4	39.4	27	26.8

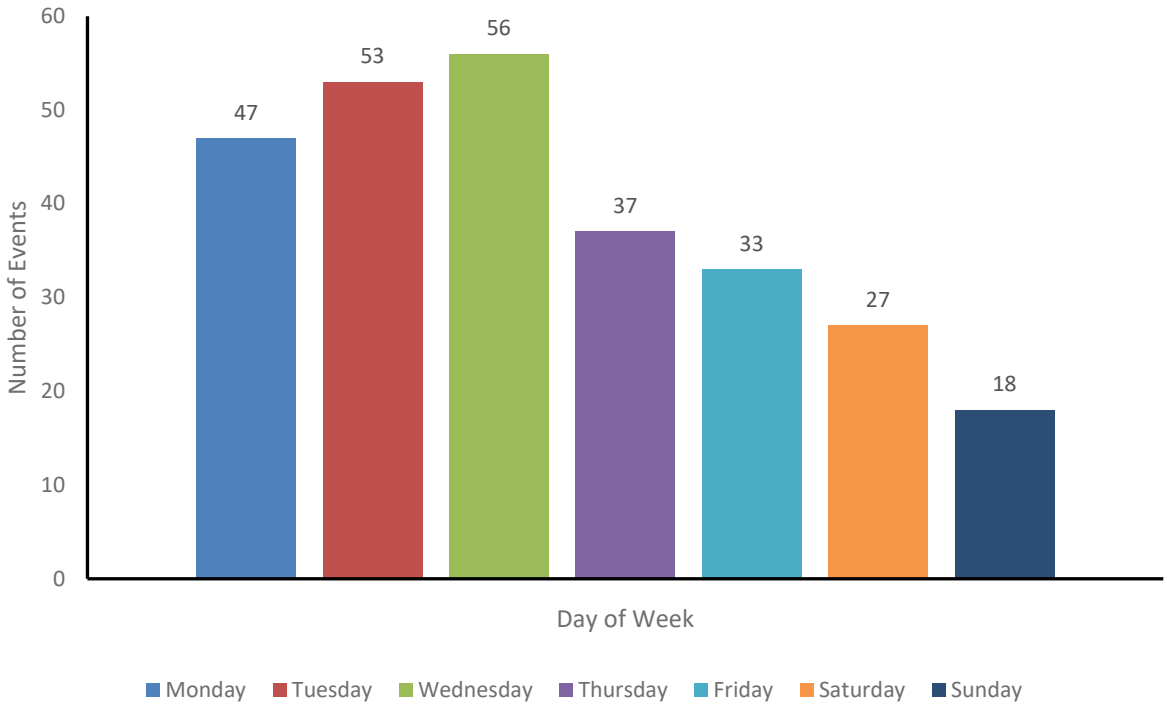

Figure 11: Sentinel events by the Day of the week, 2020.

Department or Locations where Sentinel Events Occurred

The medical/surgical department location had the highest number of reported events. Intensive/critical care, intermediate care, ER, and inpatient surgery round out the top 5 locations accounting for about two thirds of all events. This relative ranking of departments has remained consistent for several years. Up to 4 departments can be attributed for each event. There were 24 departments out of 34 that reported at least one event.

Table 21: Department or location where sentinel events occurred, 2020.

Department/Location	Count	Percent
Medical/surgical	70	28.2%
Intensive/critical care	52	21%
Intermediate care	23	9.3%
Emergency department	12	4.8%
Inpatient surgery	11	4.4%
Imaging	10	4%
Labor/delivery	10	4%
Inpatient rehabilitation unit	9	3.6%
Long term care	8	3.2%
Outpatient/ambulatory surgery	8	3.2%
Pulmonary/respiratory	8	3.2%
Psychiatry/behavioral health/geropsychiatry	6	2.4%
Neonatal unit (level 2)	3	1.2%
Anesthesia/PACU	2	0.8%
Laboratory	2	0.8%
Neonatal unit (level 3)	2	0.8%
Observational/clinical decision unit	2	0.8%
Outpatient/ambulatory care	2	0.8%
Pediatric intensive/critical care	2	0.8%
Ancillary_other	2	0.8%
Endoscopy	1	0.4%
Newborn nursery (level 1)	1	0.4%
Nursing/skilled nursing	1	0.4%
Pediatrics	1	0.4%
Total	**248**	**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: **QUPS (Initiatives Affecting Quality and Patient Safety in healthcare)**

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: **Arizona Patient Protection Legislation**

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. **California Reportable Adverse Events.**

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.

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.

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: **Oregon Patient Safety Program.**

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. **Utah Patient Safety Institute**

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 2020 sentinel event report summary form. Sixty-one (61) patient safety plans were submitted from sixty-two (62) Annual Summary Reports filed, out of eighty-three (83) facilities that are expected per NRS to file an annual summary sentinel event report. As was the case from 2009 to 2019, 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*.

For all facility sizes 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, 49 facilities in 2020 indicated they had 25 or more employees, a similar number to 52 reported in 2019, and 84 reported in 2018.

For facilities that had fewer than 25 employees, there were 34 in 2020, while in 2019 there were 15 and in 2018 43. Overall, regardless of the number of employees, the patient safety committees at 62 of the 83 facilities reporting, met as frequently as required.

Among the facilities that had 25 or more employees, 36 (73%) of the patient safety committees met monthly. Among the facilities that had fewer than 25 employees, 26 (76%) of the patient safety committees met on a quarterly basis.

Table 22: Mandated safety meetings timeliness, 2020 (orange = out of compliance).

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	36	73.5%	Yes	26	76.5%
No	7	14.3%	No	3	8.8%
Did Not Report	7	14.3%	Did Not Report	5	14.7%
Total	**49**	**100%**	**Total**	**34**	**100%**

Not all patient safety committees had the appropriate staff in attendance at the patient safety committee meetings. Some facilities that have 25 or more employees did have mandatory meeting attendance. The overall percent with mandatory meeting attendance was just under 42% in 2020, compared to 71% in 2019. The facilities with fewer than 25 employees had almost 40% in 2020, compared to 2019's 60% that met the attendance criteria.

Table 23: Mandated safety meetings staff attendance, 2020 (orange = out of compliance).

Facilities Having 25 or More Employees and Contractors (2020)			Facilities Having Fewer Than 25 Employees and Contractors (2020)		
Mandatory Staff	**Total Facilities**	**Percentage**	**Mandatory Staff**	**Total Facilities**	**Percentage**
Yes	32	41.6%	Yes	19	39.6%
No	13	16.9%	No	11	22.9%
Did Not Report	4	5.2%	Did Not Report	4	8.3%
Total (may not equal exactly 100 due to rounding)	**49**	**100%**	**Total**	**34**	**100%**

Section V: Plans, Conclusion, and Resources

Plans and Goals for the Upcoming Year

Plans can be grouped by data collection improvements and by facility participation improvements.

Data collection improvements focus on the Sentinel Event Registry's web-based sentinel event reporting system, **REDCap**. This replaced the previous submission of sentinel events via facsimile used prior to October 2016. Users of the web-based reporting tool continue to have optimum workflow issues.

In 2021, the SER will work to improve data collection in the following areas:

- Implement a survey asking about the REDCap user experience. Ask questions around ways to improve reporting workflow, ensure entry of critical information and what the healthcare facilities would like to have in the way of assistance around patient safety.
- Continue to identify and address data quality issues.
- Expand the use of required fields, and field entry validation, especially dates.
- Design, test and deploy an on-boarding procedure that includes how-to videos, a mini quiz, and a signed user agreement.
- Refine the SER's Frequently Asked Questions (FAQ) that serves as the How-To-Use reference.
- 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.
- Create the Frequently Asked Questions sections in a video format
- Assist the educational activities designed to help facilities increase their skills in root cause analysis and process improvement related to sentinel events.
- linking data to internal and eventually external reporting status dashboard are some of the areas being explored to improve the user experience and quality of data collected. Review approaches to address a constant background of facilities closing and new facilities opening, to ensure a smooth participation in the sentinel events registry, and to maintain data integrity. 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.

In 2021, the SER will work to improve healthcare facility participation in the following areas:

- Prepare a written notification regarding SB457 program changes. Include a printed set of relative NRS, that includes highlighting potential financial penalties for non-compliance. Use verification of receipt to ensure all are equally notified. This is intended for all those healthcare

facilities who have not yet enrolled as a part of the two cordial email notifications sent a year apart.
- Ensure messaging coming from the Nevada Hospital Association and the Nevada Healthcare Association to their members is consistent with the SER program and with both the intent and the letter of the NRS.
- Review approaches to address a constant background of facilities closing and new facilities opening, to ensure a smooth participation in the sentinel events registry, and to maintain data integrity.
- Open discussion to more stakeholders around developing administrative code to address facility license types that have no direct physical setting, these facility types are often staffing agencies.

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 through 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 previous medical facilities and many of the enrolled healthcare 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 patient volumes and 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:

PSQH Patient Safety Checklist

AARP Patient Checklist

The Sentinel Events Registry main page is located at:
State of Nevada Sentinel Events Registry Website

The Sentinel Events Registry Forms are located at:
State of Nevada Sentinel Events Registry's Forms Website

The Sentinel Events Registry Publications are located at:
State of Nevada Sentinel Events Registry's Publications Website

The National Quality Forum Topics in Sentinel Reporting Events is located at: **National Quality Forum Topics in Sentinel Reporting Events**

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:
State of Nevada Sentinel Events Registry Website's Link to the 2011 Update Serious Reportable Events in Healthcare

Nevada State Legislature. *Senate Bill 457*. 2019 80th Regular Session. Available at:
Nevada State Legislature. Senate Bill 457 - 2019 80th Regular Session

Citations

Nevada State Legislature. *Assembly Bill 28*. 2013 77th Regular Session. Available at: **Nevada State Legislature. Assembly Bill 28. 2013 77th Regular Session**

Nevada State Legislature. *Assembly Bill 59*. 2005 73rd Regular Session. Available at: **Nevada State Legislature. Assembly Bill 59. 2005 73rd Regular Session**

National Quality Forum. *Serious Reportable Events In Healthcare-2011 Update: A Consensus Report*. Washington, DC: NQF; 2011. Available at:
National Quality Forum. Serious Reportable Events In Healthcare-2011 Update: A Consensus Report. Washington, DC: NQF; 2011

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