Sentinel Events Annual Summary 2023

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Office of Analytics

Department of Health and Human Services

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Background

A sentinel event is an action that should “never happen” in a health care setting, including death, serious physical or psychological injury, permanent harm and severe temporary harm. Common examples of sentinel events include falls, pressure ulcers, unintended foreign items unintentionally left, or unanticipated death.

The purpose of the Annual Sentinel Events Summary Report is to inform 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 Board of Health 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 1 for the preceding year.

The count of facility types represents the number of health care facilities licensed by the Bureau of Health Care Quality and Compliance (HCQC). A facility is considered a "Participant," when a health care facility 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 199 participants in 2022 to 225 in 2023 representing an increase from 11.2% to 12.3%. Table 1 Shows the counts and percents of the different types of facility to the SER. For more information, appendix table 1 displays each facility type for the past 5 years.

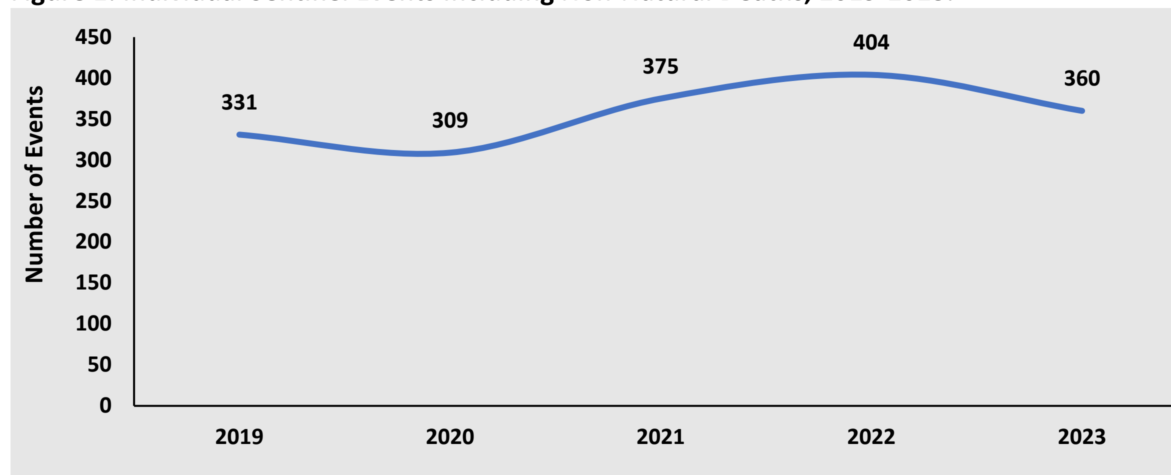
Table 1: Sentinel Event Registry Participation by Health Care Facility Type, 2023.

Facility Type Description	Count of Facility Type	SER Participant	SER Participant Percent
Adults Day Care Facility	29	1	3.4%
Alcohol or Drugs Facility Treatment	26	2	7.7%
Ambulatory Surgical Center	88	42	47.7%
Community Triage Center	2	1	50.0%
Freestanding Birthing Center	1	0	0.0%
Hospice Care Facility	229	14	6.1%
Hospital	48	42	87.5%
Independent Emergency Medical Care	1	0	0.0%
Individual Residential Care Homes	120	2	1.7%
Intermediate Care Facility	9	1	11.1%
Medical Detoxification Facility	11	2	18.2%
Medication Unit	1	0	0.0%
Narcotics Treatment Facility	15	0	0.0%
Nursing Care In the Home	237	29	12.2%
Nursing Pool	66	12	18.2%
Outpatient Facility	51	9	17.6%
Personal Care Agency	330	9	2.7%
Psychiatric Residential Treatment Facility	13	3	23.1%
Recovery Center Facility	3	0	0.0%
Renal Disease Treatment Facility	53	13	24.5%
Residential Group Facility	402	18	4.5%
Rural Clinic	20	1	5.0%
Rural Hospital	15	11	73.3%
Skilled Nursing Facility	68	13	19.1%
Total	**1,828**	**225**	**12.3%**

Individual Sentinel Events

In 2023, 81 facilities reported 360 individual sentinel events, a decrease in reported events from previous years and an 9% increase from 2019 (Figure 1).

Figure 1: Individual Sentinel Events Including Non-Natural Deaths, 2019-2023.



Of the 360 events in 2023, none were determined to be a non-sentinel event and 10 were non-natural deaths, which are included in the summary below, and are not considered an event by the National Quality Foundation. There were ultimately 360 individual sentinel events counted for 2023 (Table 2).

The number of facilities reporting individual events has increased from the previous years, from 60 to 81 from 2022-2023, roughly 4% of the total required facilities.

Table 2: Individual Sentinel Events Reported by Health Care Facility Type, 2023.

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 Drugs Treatment Facility	2	0	0	1	1
Community Triage Center	1	0	1	1	1
Hospice Care Facility	14	0	1	4	18
Hospital	42	0	5	36	244
Nursing Care In the Home Agency	29	0	0	1	1
Psychiatric Residential Treatment Facility	3	0	0	1	1
Residential Facility for Groups	18	0	0	11	25
Rural Hospital	11	0	1	10	22
Skilled Nursing Facility	13	0	0	4	14
Surgical Center for Ambulatory Patients	42	0	2	12	33
Total	**175**	**0**	**10**	**81**	**360**

Data reported as an individual sentinel event must meet the definition as classified by the National Quality Foundation (NFQ). In 2023, 40.3% of the events were falls, followed by pressure ulcers at 20.6% of the reports. For the entire list of categories, type of events, and ranks see the Appendix. In figure 3, falls and pressure ulcers continue to be leading events from previous years.

Figure 2: Sentinel Events by Type, 2023.

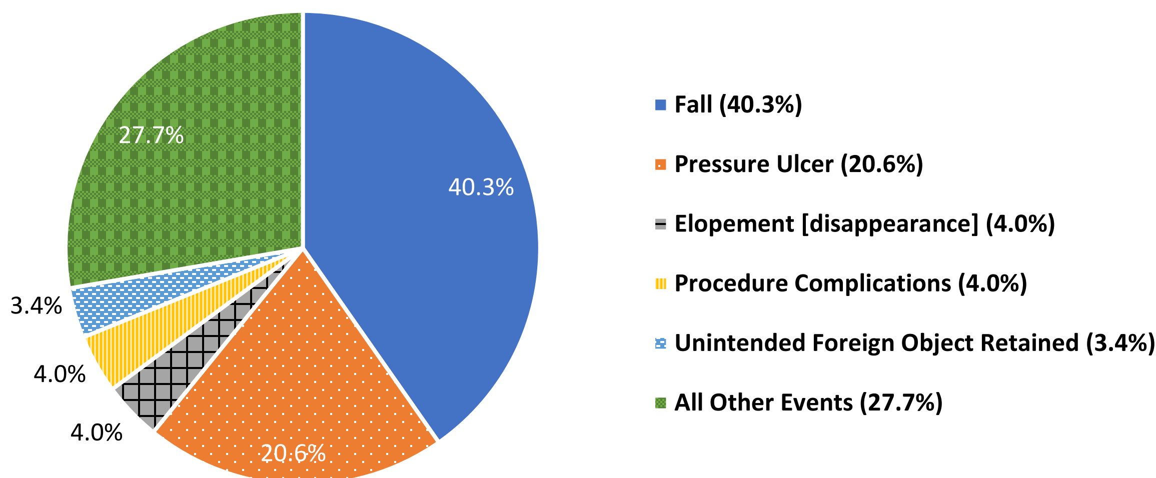
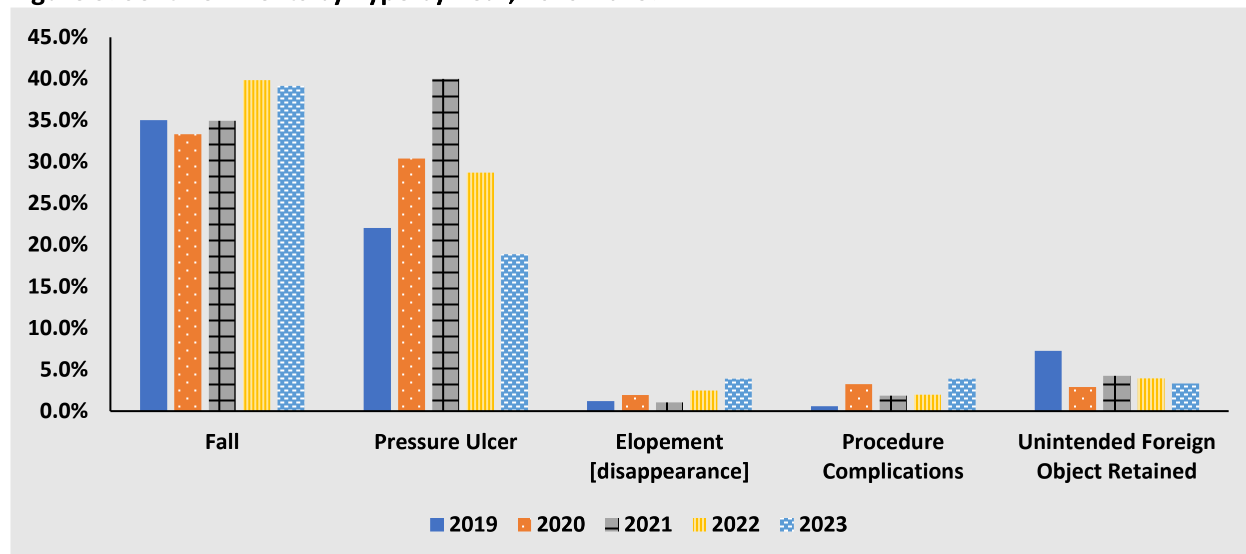


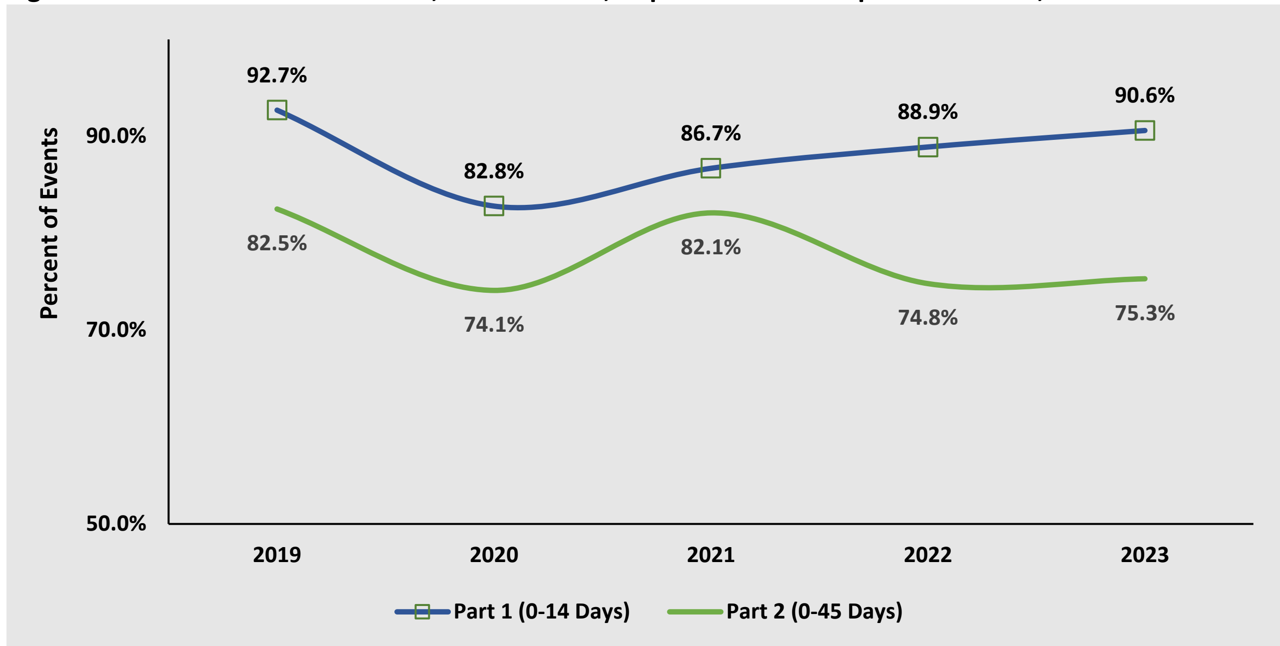
Figure 3: Sentinel Events by Type by Year, 2019-2023.



There are two parts to reporting an individual sentinel event. Part 1 is required to be submitted to the State within 14 days of becoming aware of the event. Part 2 is required to be submitted within 45 days of notifying the Sentinel Events Registry of the event.

In 2023, just over under 91% of the Part 1 events were reported in this proper timeframe which is up incrementally from 89% in 2022. For Part 2, 75.3% of the events were reported in the proper timeframe, which is slightly up from 74.8% in 2022. The timeframe compliance has varied over recent years (Figure 4).

Figure 4: Individual Sentinel Events, Parts 1 and 2, Reported in the Proper Timeframe, 2019-2023.



Annual Summary Reports

Annual Summary Reports (ASR) are completed once a year and are required to report even if no sentinel events 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.

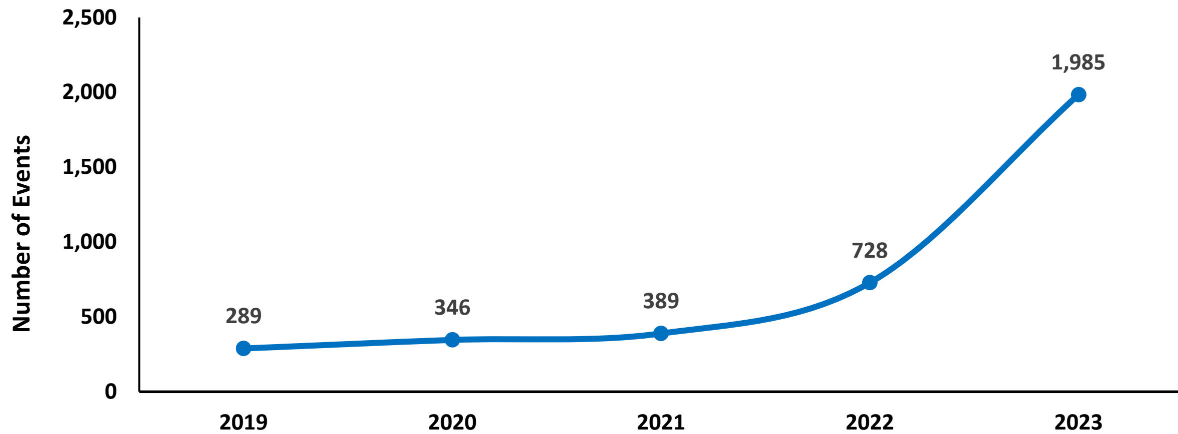
There are 1,828 facilities licensed by HCQC. All health facilities are required to report all sentinel events as they occur with the individual forms and an annual summary each year, by March 1 for the preceding year. In 2023, 207 facilities meet this requirement (11.3%), whereas 1,621 facilities did not report, which represents nearly 89**%** of the facilities. This is similar to the previous year, where only 187 facilities filed in 2022. Table 3 below shows the show the participation for facilities in 2023.

Table 3: Annual Summary Report Counts, 2023.

Event Type	N.	%
Total Facilities Licensed by HCQC	1,828	
Number of Facilities that Did Not Report	1,621	88.7%
Number of Facilities that Did Report	207	11.3%
Of Those that Did Report (n=207)		
Had No Sentinel Events	128	61.8%
Had 1 Sentinel Event	30	14.5%
Had More than 1 Sentinel Events	49	23.8%

With ASR, facilities can report multiple events that occurred during the reporting year. In Table 4 (above), 49 facilities reported more than one event in 2023. There were two facilities that had never reported before that reported a larger than expected number of falls causing the ASR events to increase significantly in 2023 (Figure 5).

Figure 5: ASR Events by Year, 2019-2023.



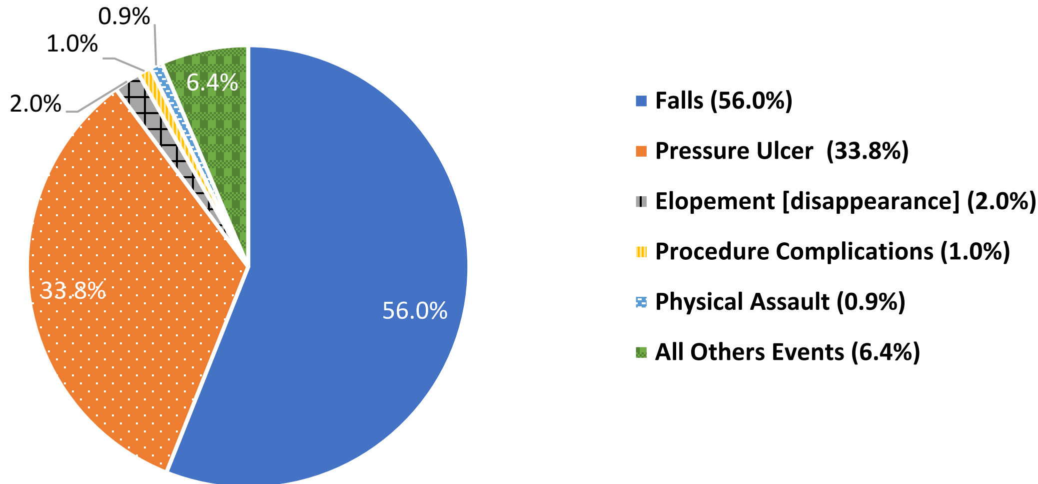
Hospitals have the best reporting to the SER out of all facility types. Of the 63 total hospitals and rural hospitals licensed by HCQC, 49 (78%) completed the ASR. The combined events reported by these hospitals make up 11% of the ASR events, compared to last year's 42%. This is due to the increase in the skilled nursing facility type, were 10 skilled nursing facilities which provided an ASR, and these reported 1,356 events (Table 4).

Table 4: Annual Summary Report Counts by Facility Type, 2023.

Facility Type Defined	Count of Facilities who Reported	Non-Natural Deaths	Count of Sentinel Events
Adult Day Care Facility	1	0	0
Alcohol or Drug Treatment Facility	2	0	1
Ambulatory Surgical Center	35	0	30
Hospice Care Facility	12	0	118
Hospital	38	5	211
Individual Residential Care Homes	2	0	0
Intermediate Care Facility	1	0	0
Medical Detoxification Facility	2	0	98
Nursing in the Home	30	0	116
Nursing Pool	12	0	0
Outpatient Facility	9	0	0
Personal Care Agency	9	0	6
Psychiatric Residential Treatment Facility	3	0	14
Renal Disease Treatment Facility	13	0	11
Residential Group Facility	16	0	5
Rural Clinic	1	0	0
Rural Hospital	11	0	19
Skilled Nursing Facility	10	0	1,356
Total	**207**	**5**	**1,985**

Data reported as an ASR event are defined by the National Quality Foundation (NFQ) as reportable. In 2023, 56% of the events were falls, followed by pressure ulcers at 33.8% of the reports (Figure 6). For the entire list of categories, type of events, and ranks see Appendix.

Figure 6: ASR by Type of Events, 2023.



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

Falls have been the leading event reported for the last 5 years, and pressure ulcers are the second. Falls and pressure ulcers make up almost 90% of the reported sentinel events for 2023, which is significantly larger than other years, which averaged 78% from 2019-2022 (Table 5).

Table 5: Leading ASR Type of Events by Year (Percent), 2019-2023.

Type of Events	2019		2020		2021		2022		2023	
	N	%	N	%	N	%	N	%	N	%
Falls	113	38.7	195	55.6	143	35.7	423	57.2	1,115	56.0
Pressure Ulcer	89	30.5	94	26.8	173	43.1	192	26.0	672	33.8
Elopement [disappearance]	3	1.0	4	1.1	11	2.7	15	2.0	39	2.0
Procedure complications	1	0.3	3	0.9	5	1.2	6	0.8	19	1.0
Physical Assault	2	0.7	3	0.9	2	0.5	4	0.5	18	0.9

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.

- ✓ Communication between all staff prior to the arrival of the patient leads to better outcomes.
- ✓ Invasive procedures benefit from a staff run down of the procedure before starting.
- ✓ Accidents can happen anytime. Staff are there to monitor and assist patients. There is no down time.
- ✓ Additional training for handling defiant patients and making all aware of escalation steps is needed.

- ✓ If staff fail to follow established policy, then the adverse outcome is what is expected.
- ✓ Staff is expected to thoroughly verify patient claims. Wound care is everyone's business.
- ✓ If you need help with a patient, call for help. Hero's call for help. Not calling for help puts everyone at risk.
- ✓ All specimen chain of custody should be verified twice.
- ✓ Being late by even 2 minutes on routine checks can lead to adverse outcomes.
- ✓ Lack of hand-off communication is unacceptable. Verbal reports are not sufficient. Sending facility, receiving facility and transporter must all confirm level of care needed by the patient/resident.

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, close to 86% of the facilities that reported the ASR did conduct patient safety meetings at the expected intervals.

Table 6: Number of Facilities that Reported Having Patient Safety Committees Meetings, 2023.

Monthly/Quarterly	N.	%
Yes	177	85.5%
No	27	13.0%
Did Not Report	3	1.5%
Total	207	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 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 2023, patient safety plans were required of medical facilities only which include only hospitals and ambulatory surgical centers. 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 a very small increase from roughly 11% to 12% 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: Sentinel Events Registry Participation by Health Care Facility Type by Year, 2019-2023.

Facility Type Description	2019	2020	2021	2022	2023
Adults Day Care Facility	35	37	34	30	29
Alcohol or Drugs Facility Treatment	26	27	23	22	26
Ambulatory Surgical Center	74	76	81	88	88
Community Triage Center	3	3	3	2	2
Freestanding Birthing Center	0	0	0	1	1
Half-Way House for Recovery	7	7	7	9	0
Hospice Care Facility	85	105	136	187	229
Hospital	54	52	51	51	48
Independent Emergency Medical Care	1	1	1	1	1
Individual Residential Care Homes	133	137	133	121	120
Intermediate Care Facility	10	11	10	9	9
Medical Detoxification Facility	4	5	7	10	11
Medication Unit	0	0	0	1	1
Narcotics Treatment Facility	16	16	15	15	15
Nursing Care In the Home	189	199	208	225	237
Nursing Pool	50	57	55	57	66
Outpatient Facility	37	42	47	51	51
Personal Care Agency	255	294	312	294	320
Prison	0	3	0	0	0
Program For Treatment Of Persons Who Commit Domestic Violence	0	0	0	27	0
Psychiatric Residential Treatment Facility	4	10	14	15	13
Public Health Laboratory	0	3	0	0	0
Recovery Center Facility	0	0	0	3	3
Renal Disease Treatment Facility	52	54	54	55	53
Residential Group Facility	384	385	395	400	402
Rural Clinic	17	19	17	20	20
Rural Hospital	14	14	14	15	15
Skilled Nursing Facility	57	64	58	67	68
Transitional Housing	6	6	0	0	0
Total	**1,513**	**1,627**	**1,675**	**1,776**	**1,828**

Table 2A: Individual Sentinel Events by Category, and Event, 2023.

Category	NQF – Event Code	N.	%
Fall	4E - Fall	141	39.2%
Pressure Ulcer	4F - Pressure ulcer (stage 3 or 4 or unstageable)	68	18.9%
Elopement	3B - Elopement (disappearance)	14	3.9%
Surgery	1C - Procedure complication(s)	14	3.9%
Surgery	1D - Unintended retained foreign object	12	3.3%
Burn	5C - Burn	11	3.1%
Death Not-Natural	8 - Death - Other than Natural Causes (SB457)	10	2.8%
Physical Harm	7D - Physical Assault	10	2.8%
Sexual Related	7C - Sexual assault	8	2.2%
Self-Harm Related	3C - Suicide - attempted	7	1.9%
Surgery	1A - Surgery on wrong site (body part)	6	1.7%
Gas	5B - No gas from system designated for gas to be delivered	5	1.4%
Medication error	4A - Medication error (wrong drug)	5	1.4%
Restraint Related	5D - Use of Physical Restraint(s)	5	1.4%
Medication error	4A - Medication error (wrong dose)	4	1.1%
Pressure Ulcer	4F - Pressure ulcer (stage 3 or 4 or unstageable) with HAI	4	1.1%
Self-Harm Related	3C - Self harm	4	1.1%
Sexual Related	7C - Sexual abuse	3	0.8%
Surgery	1C - Wrong surgery (invasive procedure) performed	3	0.8%
Device	2B - Device failure	2	0.6%
Discharge	3A – Discharge/release of patient unable to make decisions	2	0.6%
Failure to Communicate	4I - Failure to communicate (other)	2	0.6%
Medication error	4A - Medication error (wrong time)	2	0.6%
Self-Harm Related	3C - Suicide	2	0.6%
Specimen Related	4H - Specimen Loss (irretrievable and/or irreplaceable)	2	0.6%
Surgery	1B - Surgery (invasive procedure) on wrong patient	2	0.6%
Air embolism	2C - Air embolism	1	0.3%
Blood	4B - Error in administration of blood products	1	0.3%
Failure to Communicate	4I - Failure to communicate laboratory test result	1	0.3%
Failure to Communicate	4I - Failure to communicate radiology test result	1	0.3%
Death	1E - Intra- or post-operative death	1	0.3%
Medication error	4A - Medication error (wrong patient)	1	0.3%
Medication error	4A - Medication error (wrong route of administration)	1	0.3%
Physical Harm	7D - Physical Assault - Attempted	1	0.3%
Sexual Related	7C - Sexual abuse - attempted	1	0.3%
Specimen Related	4H - Specimen ID Error	1	0.3%
Use of Contaminated	2A - Use of contaminated device(s)	1	0.3%
Use of Contaminated	2A - Use of contaminated drug(s)	1	0.3%
Total (Percentages may not add up to 100% due to rounding)		**360**	**100.0%**

Table 3A: Annual Summary Report Events by Category, and Event, 2023.

Category	NQF – Event Code	N	%
Fall	4E - Fall	1,115	56.0%
Pressure Ulcer	4F - Pressure ulcer (stage 3, 4, unstageable)	393	19.7%
Pressure Ulcer	4F - Pressure ulcer (stage 1 or 2)	170	8.5%
Pressure Ulcer	4F - Pressure ulcer (stage 3, 4 unstageable) with HAI	109	5.5%
Elopement	3B - Elopement (disappearance)	39	2.0%
Surgery	1C - Procedure complication(s)	19	1.0%
Physical Harm	7D - Physical Assault	18	0.9%
Medication error	4A - Medication error (wrong drug)	17	0.9%
Medication error	4A - Medication error (wrong dose)	14	0.7%
Surgery	1D - Unintended retained foreign object	11	0.6%
Burn	5C - Burn	7	0.4%
Self-Harm Related	3C - Suicide - attempted	7	0.4%
Self-Harm Related	3C - Self harm	6	0.3%
Sexual Related	7C - Sexual assault	6	0.3%
Death	8 - Death - Other than Natural Causes (SB457)	5	0.3%
Gas	5B - No gas from system designated for gas delivered	4	0.2%
Medication error	4A - Medication error (wrong patient)	4	0.2%
Medication error	4A - Medication error (wrong rate)	4	0.2%
Medication error	4A - Medication error (wrong time)	4	0.2%
Physical Harm	7D - Physical Assault - Attempted	4	0.2%
Restraint Related	5D - Use of Physical Restraint(s)	4	0.2%
Surgery	1A - Surgery (invasive procedure) on wrong site	4	0.2%
Medication error	4A - Medication error (wrong preparation)	3	0.2%
Self-Harm Related	3C - Self harm - attempted	3	0.2%
Self-Harm Related	3C - Suicide	3	0.2%
Device	2B - Device failure	2	0.1%
Medication error	4A - Medication error: route of administration	2	0.1%
Air embolism	2C - Air embolism	1	0.1%
Blood	4B - Error in administration of blood products	1	0.1%
Discharge	3A - Discharge of patient unable to make decisions	1	0.1%
Failure to Communicate	4I - Failure to communicate (other)	1	0.1%
Failure to Communicate	4I - Failure to communicate laboratory test result	1	0.1%
Failure to Communicate	4I - Failure to communicate radiology test result	1	0.1%
Death	1E - Intra- or post-operative death	1	0.1%
Sexual Related	7C - Sexual abuse - attempted	1	0.1%
Sexual Related	7C - Sexual assault - attempted	1	0.1%
Specimen Related	4H - Specimen ID Error	1	0.1%
Specimen Related	4H - Specimen Loss (irretrievable and/or irreplaceable)	1	0.1%
Surgery	1B - Surgery (invasive procedure) on wrong patient	1	0.1%
Surgery	1C - Wrong surgery (invasive procedure) performed	1	0.1%
Total (Percentages may not add up to 100% due to rounding)		**1,990**	**100.00%**