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2024 Sentinel Events Registry Summary Report

Office of Analytics

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Department of Health and Human Services

Helping people. It's who we are and what we do.

Agenda

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

History of the Sentinel Events Registry

In 1999, the Institute of Medicine (IOM) published "To Err Is Human: Building a safer Health System." This book brought public attention to the impact from adverse events in health care settings.

From 2000 to 2005, the State of Nevada initiated formal input, establishing a Sentinel Events Registry steering committee and a workgroup with representatives from government and industry, which held public meetings and training sessions.

Mandatory sentinel events reporting is not meant to be punitive. Instead, the intent is to see the SER data and 'lessons learned' utilized throughout the State to prevent further occurrences of sentinel events and enhance patient safety.

Since 2009, Nevada law has required sentinel event reporting, with electronic filing since 2016. In 2019, SB 457 added health facilities and non-natural deaths to be reported.

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 Division of Public and Behavioral Health 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?

Facilities need immediate investigation and response, and sentinel event reporting motivates that, resulting in insight that can be a useful continuous quality and patient safety improvement program tool. Performing a root cause analysis (RCA) can assist reporting facilities in both meeting sentinel event reporting requirements and achieving continuous quality improvement.

Properly conducted investigations can result in improved action plans designed to implement improvements to risk reduction and include means to monitor the effectiveness of those improvements.

Data Collection Methods

Using the Research Electronic Data Capture (REDCap) platform (projectredcap.org), reporting facilities' patient safety officers or their designated reporters are able to 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) — 14 days from event awareness
- Part 2: Factor areas, departments, and root cause analysis findings — 45 days after notification

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

- 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, 2024

There were 1,953 licensed health facilities in the State of Nevada at the end of 2024.

Participation

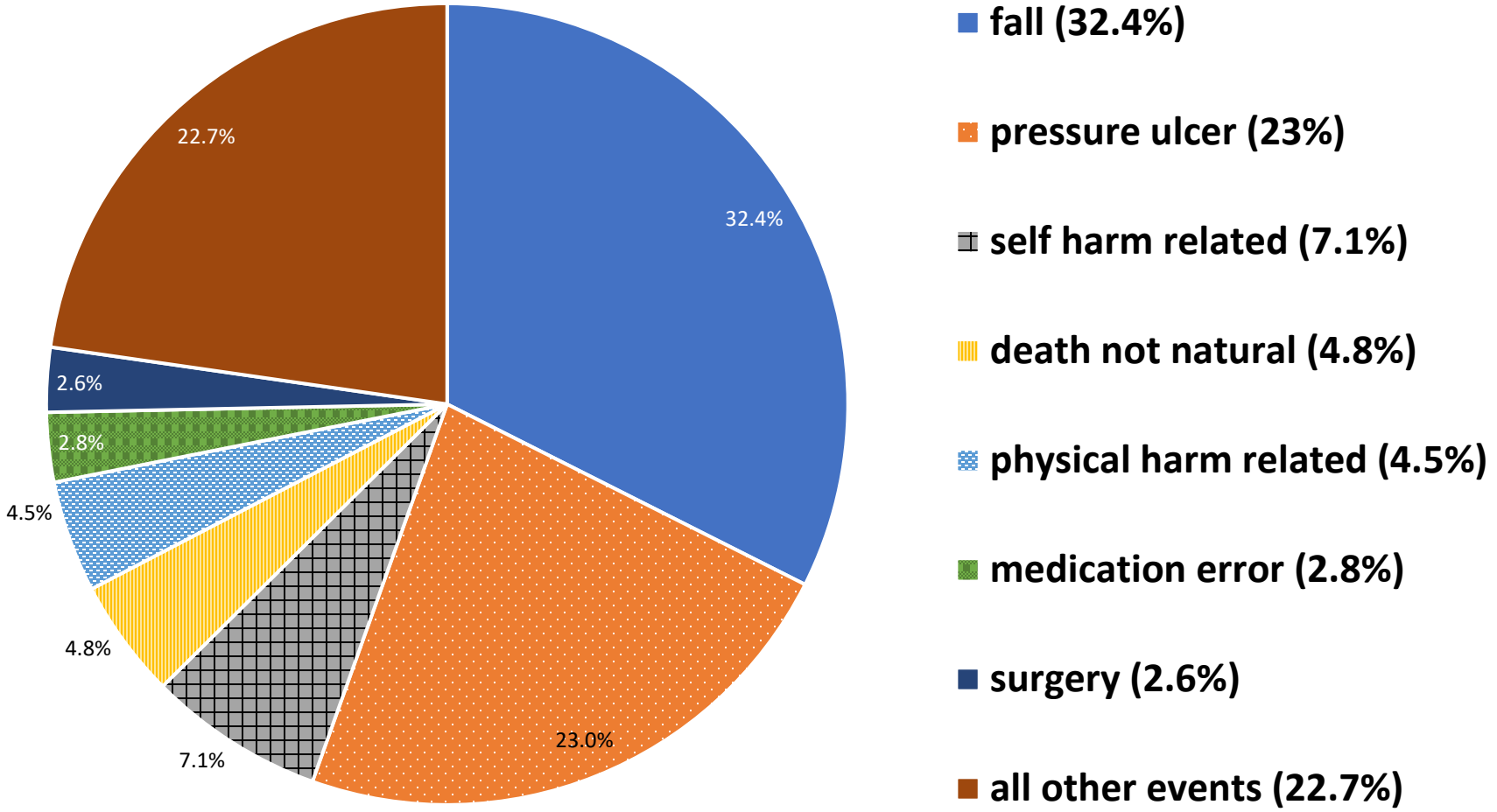
- 238 facilities participated in at least one reporting mechanism of the SER
- 12.2% of all facilities participate
- 69.4% of medical facilities participate
- 10.0% of health facilities participate

- 73 facilities reported at least one individual event (calendar year 2024)
- 224 facilities filed an annual summary report (due March 1 for previous calendar year)

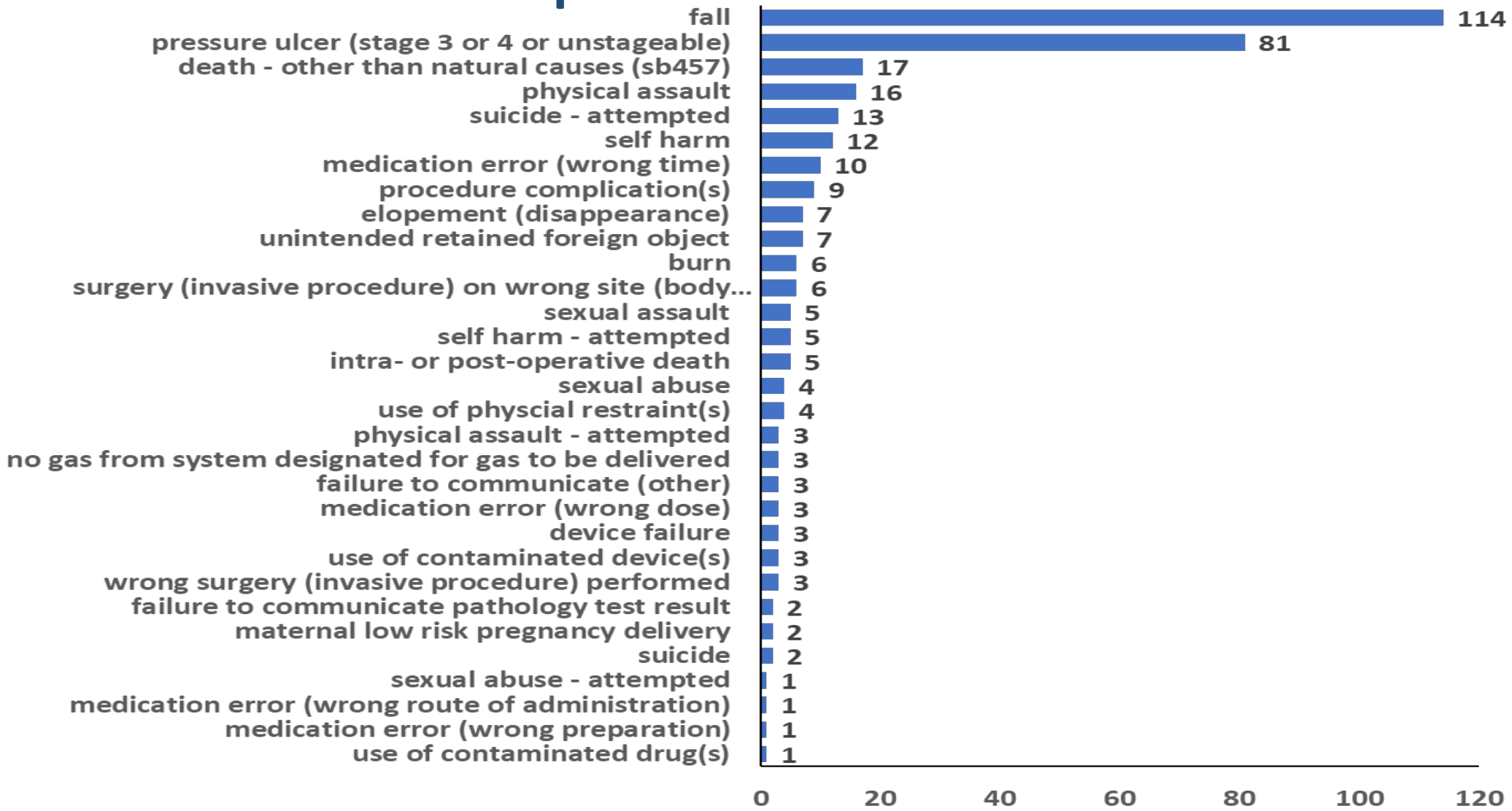
Key findings

Despite receiving email notification each January, participation remains low. The SER findings represent about 12% of all the health facilities in Nevada.

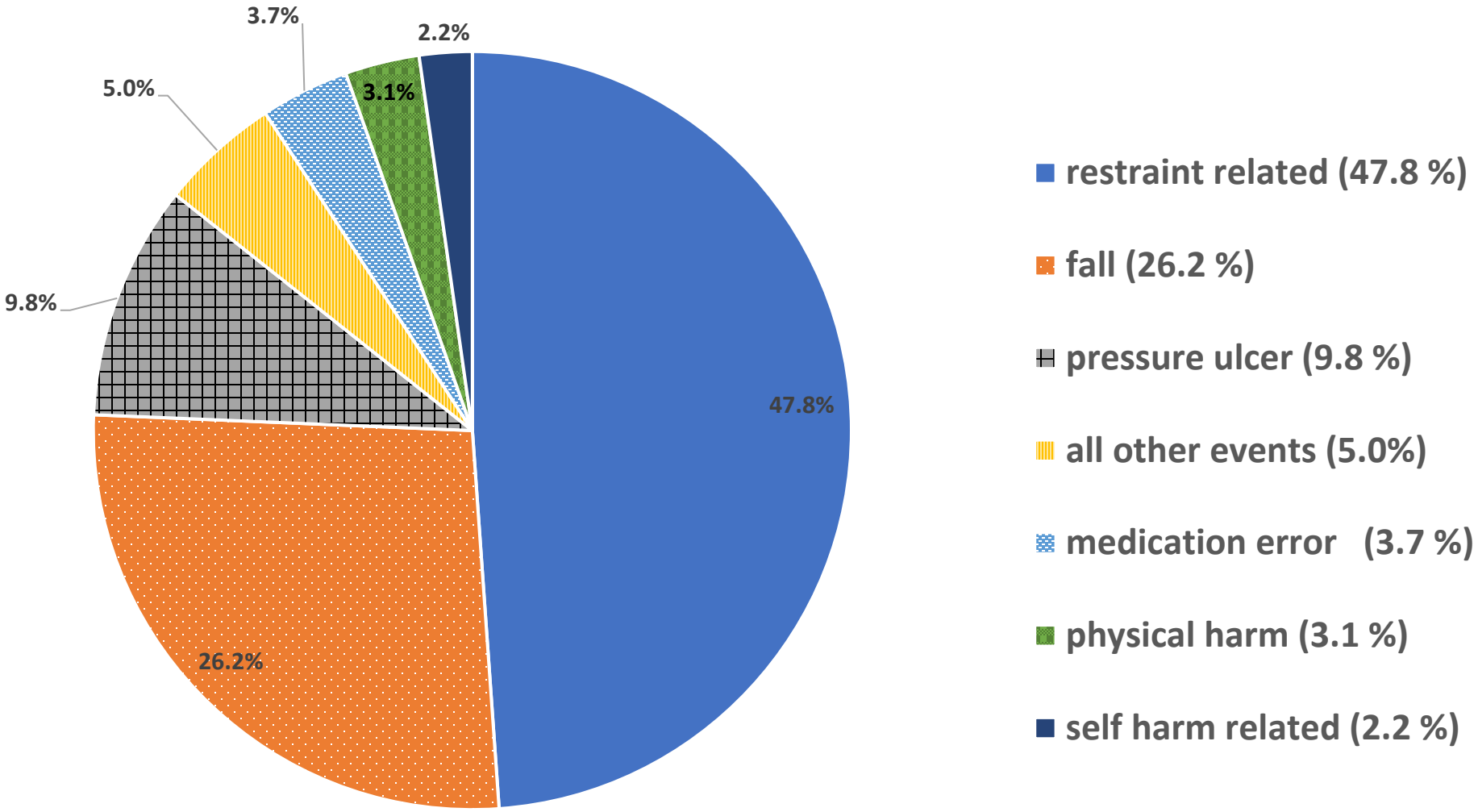
Types of Sentinel Events Reported in 2024



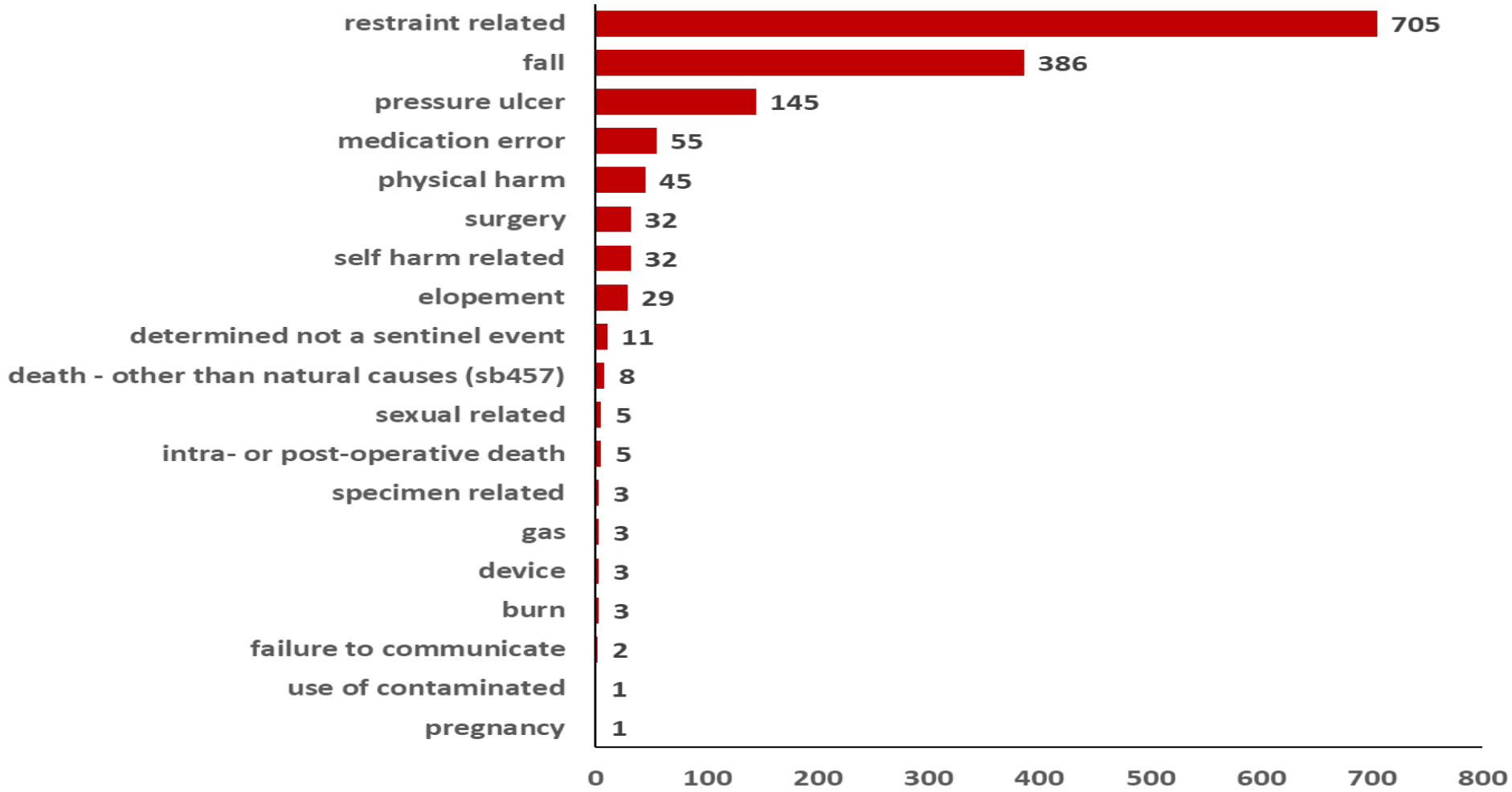
Individual Sentinel Events Reported in 2024



Sentinel Events from 2024 Annual Summary Report

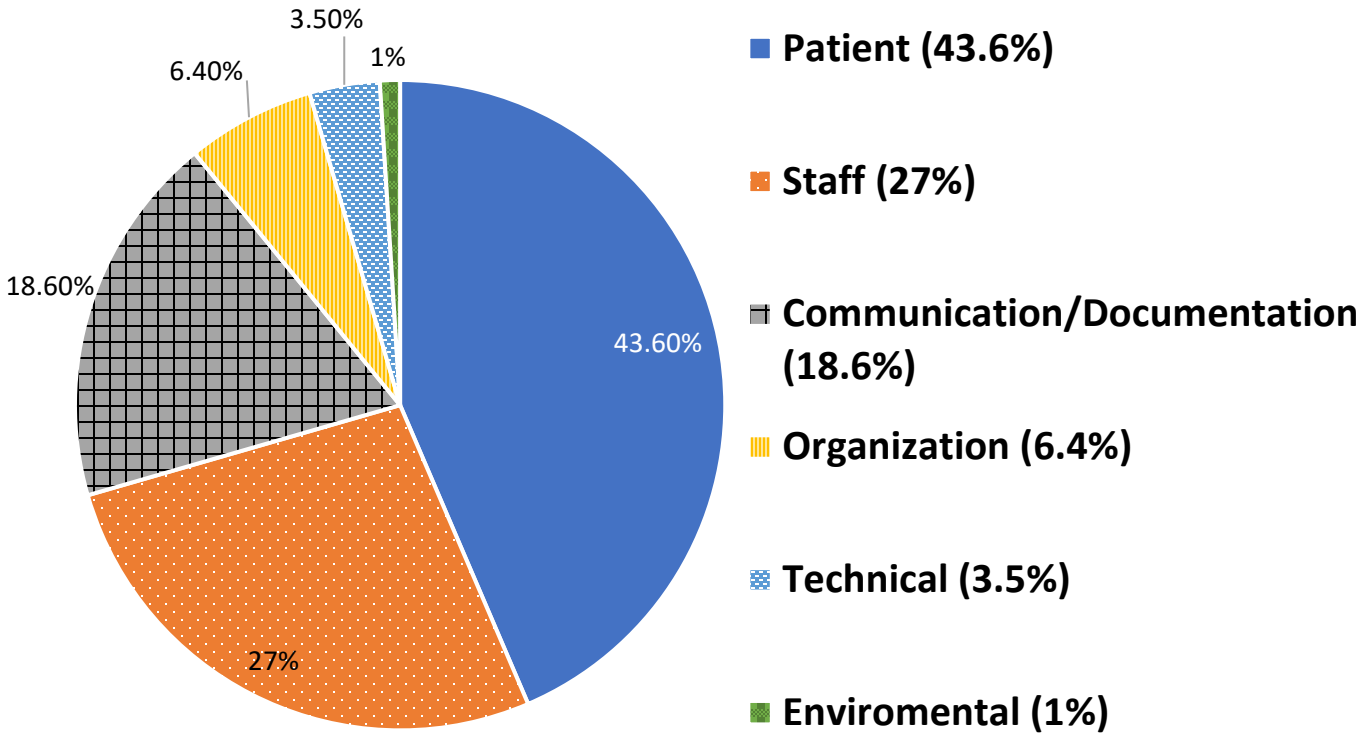


Sentinel Event Counts from 2024 Annual Summary Report



Factors Attributed

Contributing Factors to Events	%
Patient	43.6%
Staff	27.0%
Communication/documentation	18.6%
Organization	6.4%
Technical	3.5%
Environment	1.0%
Total (percentages may not add up to 100% due to rounding)	100%



Safety Meetings

Facilities in compliance with NRS expectation – Patient safety meetings Monthly (>25 employees and contractors) or quarterly (<=25 employees and contractors)		
Compliance with meeting frequency and attendance per NRS expectation	Total facilities	Percentage
Yes	185	82.6%
No (non-compliant)	36	16.1%
Did not report	3	1.3%
Total	224	100%

Sentinel Event Lessons Learned

From lessons learned in event root cause analysis results:

- ✓ All paperwork must be cross examined to ensure they all match before hand off.
- ✓ Recognize when distractions are present and take appropriate steps to ensure protocols are followed.
- ✓ If you see something that is not as it should be, do something. Get help, notify other staff and supervisors.
- ✓ Review fall prevention procedures and communicate patient vulnerabilities.
- ✓ Despite the good intentions of non staff, only staff should assist patients.
- ✓ If you must respond to a call light, assign another staff to monitor for additional call lights.
- ✓ Mandatory training covering mental health crises must be completed annually, with policy review, scenario training and passing an exam included.
- ✓ Documentation is key. Without documentation, did it happen?
- ✓ Check-off lists must be followed.

SER Frequently Asked Questions

https://dpbh.nv.gov/Programs/SER/dta/FAQs/SER_Frequently_Asked_Questions/

Sentinel Events Registry's FAQ link

The SER FAQ covers the ‘What’ and the ‘How’ of the Sentinel Events Registry, and replaces any previous guides, or manuals.

Minimum expectations, timelines, and reporting of adverse events, and submission of the annual summary report, are covered.

Event reporting part 1 notification, and part 2 root cause analysis, the annual summary report, and the contact form processes are explained, including examples of the input forms as found in the REDCap reporting platform.

SER Plans and Achievements

Plans:

- SER dashboard is in progress.
- Create a series of short instructional videos.

Achievements:

- Updated program website (dpbh.nv.gov/ser).
- Cleaned up data issues.

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.

Reporting levels for the year 2024 were very similar to previous years. Issues that continue revolve around participation rates, training new PSOs and DR 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.

Contact Information

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https://dpbh.nv.gov/SER/

Sentinel Events Registry's link

Questions?