

2009 ANNUAL SENTINEL EVENT SUMMARY REPORT



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Nevada State Health Division
Bureau of Health Care Quality and Compliance
Quality Improvement Team**

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PURPOSE

Legislation passed during the 2009 Legislative Session requires the Nevada State Health Division (NSHD) to compile the annual sentinel event report summaries and submit the compilation to the State Board of Health each year by June 1. This is the first annual summary report to be compiled pursuant to Nevada Revised Statutes (NRS) [439.843](#).

SENTINEL EVENT DEFINED

[NRS 439.830](#) defines a sentinel event as:

an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function.

The Sentinel Events Registry is a database used to collect, analyze, and evaluate such adverse events. The intent is that the reporting of these sentinel events will reveal systemic issues across facilities so that they may be addressed more widely through quality improvement and educational activities.

[NRS 439.835](#) requires that medical facilities report sentinel events to the Health Division. As specified in [NRS 439.805](#), the medical facility types required to report sentinel events are as follows:

- hospitals
- obstetric centers
- surgical centers for ambulatory patients
- independent centers for emergency medical care

METHODOLOGY

On December 29, 2009, each medical facility was sent a sentinel event report summary form to be completed and returned to the Health Division by March 1, 2010, requesting the following information:

- 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](#).

The Health Division sent the form to 113 mandatory sentinel event reporting medical facilities. These medical facilities included 59 hospitals, 53 ambulatory surgical centers, and 1 independent center for emergency medical care. Although obstetric centers are also required to report sentinel events, there are none currently licensed in Nevada. Of the 113 mandatory sentinel event reporters, all returned the required sentinel event report summary form. These reports were then aggregated to provide a summary of the required information.

This section of the report provides information based on what was submitted by the medical facilities on their annual summary form and as required by [NRS 439.843](#). Another section compares what was submitted on the summary forms to what has been received and recorded in the sentinel event registry for 2009.

SENTINEL EVENT SUMMARY REPORT INFORMATION

This section provides information regarding the total number of sentinel events indicated by the medical facilities as reported on the sentinel event report summary forms as well as a breakdown of the event types. It also provides information regarding the medical facilities' patient safety plans and patient safety committees.

EVENT TYPES AND TOTALS

Table 1 lists the types of sentinel events reportable with a total for each as indicated on the medical facilities' annual sentinel event report summary forms. A percentage of all sentinel events reported is also provided for each. In 2009, the medical facilities indicated that they had reported a total of 254 sentinel events.

Table 1 – sentinel event type totals from the 2009 sentinel event report summary forms

event type	total	percentage
abduction – adult	0	0.0%
abduction – adult – attempted	0	0.0%
abduction – child	0	0.0%
abduction – child – attempted	0	0.0%
abduction – infant	0	0.0%
abduction – infant – attempted	0	0.0%
assault – attempted battery	1	0.4%
battery	0	0.0%
burn	6	2.4%
contaminated product/device	6	2.4%
discharge to wrong family/care-giver – adult	0	0.0%
discharge to wrong family/care-giver – child	0	0.0%
discharge to wrong family/care-giver – infant	0	0.0%
electric shock (environmental)	0	0.0%
elopement	8	3.1%
facility-acquired infection – catheter-related urinary tract infection	5	2.0%
facility-acquired infection – non-catheter-related urinary tract infection	13	5.1%
facility-acquired infection – central line-related bloodstream infection	3	1.2%
facility-acquired infection – non-central line-related bloodstream infection	2	0.8%
facility-acquired infection – <i>decubitus ulcer</i> (stage 3 or 4)	1	0.4%
facility-acquired infection – surgical site infection	38	15.0%
facility-acquired infection – ventilator associated pneumonia	2	0.8%
facility-acquired infection – other	13	5.1%
fall	32	12.6%

event type	total	percentage
homicide	1	0.4%
homicide – attempted	0	0.0%
impersonation of health-care professional	0	0.0%
infant perinatal	1	0.4%
maternal intrapartum	3	1.2%
medication error(s)	7	2.8%
not a sentinel event	0	0.0%
procedure complication(s)	34	13.4%
rape	0	0.0%
rape – attempted	0	0.0%
restraint	1	0.4%
suicide	5	2.0%
suicide – attempted	10	3.9%
transfusion	1	0.4%
treatment delay	9	3.5%
treatment error	10	3.9%
wrong patient/wrong surgery procedure	3	1.2%
wrong site/wrong surgery procedure	6	2.4%
other	33	13.0%
total	254	

A total of 33 sentinel events were categorized as ‘other.’ Table 2 lists the descriptions provided by the medical facilities with a total given for each category.

Table 2 – descriptions of sentinel events indicated as ‘other’

‘other’ event descriptions	total
assault within 24-hours of an emergency room visit	1
death after discharge from acute combined drug toxicity	1
death from sarcodosis	1
defective equipment	1
electrical fire started by bed cord	1
facility-acquired pressure ulcer	1
fracture prior to admission	1
hostage situation	1
loss of vision	1
overdose without injury	1
perforated bowel	1
post-operative death	3
pre-operative death	1
punched windows with injury	5
retained foreign object	6
risk of infection with physical injury for 3 patients	1
sexual familiarity	2
surgical complication	1

'other' event descriptions	total
surgical equipment failure	1
unexpected death	1
unsuccessful resuscitation of infant found in mother's bed	1
total	33

A total of 13 sentinel events were categorized as 'facility-acquired infection – other.' Table 3 lists the descriptions provided by the medical facilities with a total given for each category.

Table 3 – descriptions of sentinel events indicated as 'facility-acquired infection – other'

'facility-acquired infection – other' event descriptions	total
<i>E coli</i> in sputum on ventilator, <i>Acinetobacter baumannii</i> in sputum culture	2
no description given	4
non-ventilator associated respiratory infection	3
skin/wound infection	3
stool infection	1
total	13

According to the summary reports provided by medical facilities, facility-acquired infections were the most common type of sentinel event reported, accounting for 77 of the sentinel events reported. Of these, surgical site infections were predominant at 38 reports. Complications during a medical procedure were second most common at 34, and falls were third at 32. Overall, facility-acquired infections amount to almost one-third (30.3%) of all sentinel events reported.

PATIENT SAFETY PLANS

In accordance with [NRS 439.865](#), each medical facility is required to develop an internal patient safety plan to improve 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. The facility shall also require compliance with its patient safety plan.

All medical facilities, except one hospital submitted a patient safety plan to the Health Division. The one that did not submit indicated that it did not have a patient safety plan but was now working to create one. There was a wide variety in the patient safety plans submitted. They ranged from fully comprehensive plans to a plan with a few hand written sentences, which did not comprehensively address the safety needs of patients in a medical facility. Patient safety plans are addressed in [NRS 439.865](#), but statutes do not delineate the minimum requirements for a plan.

PATIENT SAFETY COMMITTEES

In accordance with [NRS 439.875](#), medical facilities must establish a patient safety committee.

What is the composition of the patient safety committee and how often is it required to meet?

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 composed of:

- 1) The patient safety officer of the medical facility;
- 2) 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
- 3) 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 composed 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*.

In either case, 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.

How often are the patient safety committees meeting?

According to the summary reports provided by medical facilities, 31 of 113 facilities (27.4%) met on a monthly basis, 20 (17.7%) met on a quarterly basis, 45 (39.8%) did not meet or may have met but failed to indicate it on the summary form, and 17 (15.0%) did not clearly mention how often the patient safety committee met; therefore, it could not be determined how often the patient safety committee met. The frequency of meetings, whether monthly or quarterly, is dependent on the number of employees employed by a facility. Facilities with fewer than 25 employees and contractors must meet *at least once every calendar quarter*. Facilities with 25 or more employees must meet *at least once each month*. Because the number of employees per facility was not available for this report and due to the other factors listed here, compliance with this regulatory requirement could not be fully assessed. What is known is that 51 (45.1%) met at a minimum, on a quarterly basis. Table 4 lists the frequency of patient safety committee meetings.

Table 4 – frequency of patient safety committee meetings

frequency	total	percentage
monthly	31	27.4%
quarterly	20	17.7%
not meeting	45	39.8%
not clear	17	15.0%
total	113	

Are the appropriate people attending the patient safety committee meetings?

According to the summary reports provided by medical facilities, 41 of 113 facilities (36.3%) met all of the requirements, 24 (21.2%) had all of the appropriate staff in attendance except for a CEO or CFO (for facilities which have fewer than 25 employees) or a member of the executive or governing body of the medical facility (facilities with 25 or more employees), and 48 (42.5%) of facilities did not have the appropriate people attending the meetings or it could not be determined based on the information provided on the summary form. Due to the factors listed in this analysis, compliance with this regulatory requirement could not be fully assessed, although a common trend found was a failure to have a CEO/CFO or one member of the executive or governing body of the facility as required by statutes. Table 5 lists the frequency of appropriate staff attending patient safety committees.

Table 5 – frequency of appropriate staff attendance at patient safety committee meetings

requirement met?	total	percentage
yes	41	36.3%
no	48	42.5%
yes, except for CEO/CFO or one member of the executive or governing body of the facility	24	21.2%
total	113	

SENTINEL EVENT SUMMARY REPORT INFORMATION VERSUS SENTINEL EVENT REGISTRY DATA

This section compares what was submitted on the summary forms to what has been received and recorded in the sentinel event registry for 2009.

EVENT TYPES AND TOTALS

Similar to Table 1, Table 6 lists the types of sentinel events reportable with totals for the number reported according to both the summary forms and the reports recorded in the sentinel event registry. In 2009, a total of 254 sentinel events were indicated as reported according to the summary forms versus 237 as recorded in the sentinel event registry, 6 of which were determined not to be sentinel events, bringing the actual total to 231.

The totals provided from the sentinel event registry are based on the year in which the sentinel event occurred; however, the 2009 sentinel event report summary form did not explicitly provide guidance to the facilities about which date field to use; therefore, they may have used the date the event occurred, the date the facility became aware of the event, or even the date the facility reported the event. This fact may have contributed to the discrepancies observed between the total number of sentinel events indicated as reported on the summary forms and the total number of sentinel events recorded in the sentinel event registry.

Table 6 – sentinel event type totals from the 2009 sentinel event report summary forms and sentinel event registry

event type	summary	registry
abduction – adult	0	0
abduction – adult – attempted	0	0
abduction – child	0	0
abduction – child – attempted	0	0
abduction – infant	0	0
abduction – infant – attempted	0	0
assault – attempted battery	1	1
battery	0	0
burn	6	4
contaminated product/device	6	5
discharge to wrong family/care-giver – adult	0	0
discharge to wrong family/care-giver – child	0	0
discharge to wrong family/care-giver – infant	0	0
electric shock (environmental)	0	0
elopement	8	5
facility-acquired infection – catheter-related urinary tract infection	5	5
facility-acquired infection – non-catheter-related urinary tract infection	13	12
facility-acquired infection – central line-related bloodstream infection	3	1
facility-acquired infection – non-central line-related bloodstream infection	2	3
facility-acquired infection – <i>decubitus ulcer</i> (stage 3 or 4)	1	1
facility-acquired infection – surgical site infection	38	33

event type	summary	registry
facility-acquired infection – ventilator associated pneumonia	2	1
facility-acquired infection – other	13	11
fall	32	33
homicide	1	0
homicide – attempted	0	0
impersonation of health-care professional	0	0
infant perinatal	1	1
maternal intrapartum	3	3
medication error(s)	7	9
not a sentinel event	0	6
procedure complication(s)	34	27
rape	0	0
rape – attempted	0	0
restraint	1	1
suicide	5	4
suicide – attempted	10	10
transfusion	1	1
treatment delay	9	10
treatment error	10	15
wrong patient/wrong surgery procedure	3	3
wrong site/wrong surgery procedure	6	6
other	33	26
total	254	237

LESSONS LEARNED

What should be done differently for future annual summary reports?

The sentinel event report summary form needs to be revised with fields added to ascertain details about specific facilities and their statutory obligations. Revisions to the form will address the following points:

- **Which date to use for a sentinel event year?**

The form did not provide guidance to facilities on whether to use the date the event occurred, the date the facility became aware of the event, or the date the facility reported the event. This may have led to discrepancies between the actual number of sentinel events reported and the number of sentinel events indicated as reported for the calendar year. The 2010 sentinel event report summary form has already been revised to include such guidance.

- **Does your facility have more or less than 25 employees?**

Certain regulatory requirements depend on whether a facility has more or less than 25 employees; however, this was not captured on the 2009 sentinel event report summary form. Including questions regarding this would enable NSHD to determine whether a facility's patient safety committee met as frequently as required in statutes as well as whether it had the appropriate composition.

- **Does your facility have a patient safety officer? What is his/her name/position and title?**
Not every facility specified whether they had a patient safety officer, despite the regulatory requirement that one serve on the patient safety committee. Due to this fact, this question will be added to the 2010 sentinel event report summary form.
- **Does your facility have regular patient safety committee meetings? How often does the committee meet?**
As the frequency of patient safety committee meetings was not explicitly asked for on the current sentinel event report summary form, many of the summaries were not clear about whether or how frequently such meetings were being held. A question to this effect will be added to the 2010 sentinel event report summary form.
- **Are the appropriate people attending the patient safety committee meetings?**
As the annual summary form did not explicitly list the people required to attend the patient safety committee meetings, many of the summaries were not clear as to whether the appropriate people were attending. A check-off list of the required people will be added to the 2010 sentinel event report summary form, in which facilities can check-off who is on the committee.

IMPROVEMENTS TO BE MADE

- Revise sentinel event reporting forms and put them in an electronic format making it quicker and easier for facilities to report.
- Run monthly reports of facilities that do not report sentinel events and follow up with these facilities.
- Provide training to facilities on sentinel event regulations, definitions, and reporting requirements.
- Develop and send out a technical bulletin to sentinel event reporters with interpretive guidelines of a sentinel event and regulatory requirements.
- Patient Safety Plans – propose regulations to address the minimum components of a safety plan. Draft regulations pursuant to [NRS 439.843](#) will reflect minimum components of a safety plan.
- A comprehensive sentinel event policy has been developed and is undergoing the approval process. The draft sentinel events policy includes:
 - Review of reported sentinel events and provision of alerts as needed;
 - Conduct audits/investigations of medical facilities as needed; and

- Apply sanctions as necessary (pursuant to [NRS 439.885](#)) for failure to report a sentinel event, for failure to adopt and implement a patient safety plan pursuant to [NRS 439.865](#), and for failure to establish a patient safety committee or failure of such a committee to meet pursuant to the requirements of [NRS 439.875](#).
- Review and analyze reported sentinel events data to capture trends which may be used to target areas for improvement.
- Produce aggregated sentinel events reports that include:
 - Sentinel events reported by facility type in an aggregated manner;
 - Sentinel events findings, contributing factors/causes and corrective actions taken by facilities;
 - Sentinel events reported by department of occurrence if applicable;
 - Number of events that resulted in serious physical injury, psychological injury or death;
 - Number of events that may have had a risk of resulting in a serious physical injury, psychological injury or death, but did not; and
 - Baseline data to allow analysis of statistical significance of sentinel events.

These reports will help develop policy, identify areas for improvement and educational opportunities to improve patient safety in medical facilities, and help to support health-care personnel in their quest to improve the quality of care in their facilities.