Sentinel Events Annual Summary 2024

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Office of Analytics

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Contents

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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 in a surgical site, 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 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 Forum definition.

Individual Event 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 439.800.

Sentinel Events Reporting Overview

All health facilities are required to report all sentinel events as they occur with an individual event report and an annual summary report submitted by March 1st 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) as of January 2025. A facility is considered a 'Participant,' when a health care facility submitted at least one individual report and/or submitted the Annual Summary Report 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 225 participants in 2023 to 239 in 2024 representing a slight decrease from 12.3% to 11.9% when compared to all licensed facilities. This is related to the increase in total licensed facilities in 2024. Table 1 shows the counts and percents of the different types of facilities reporting to the SER.

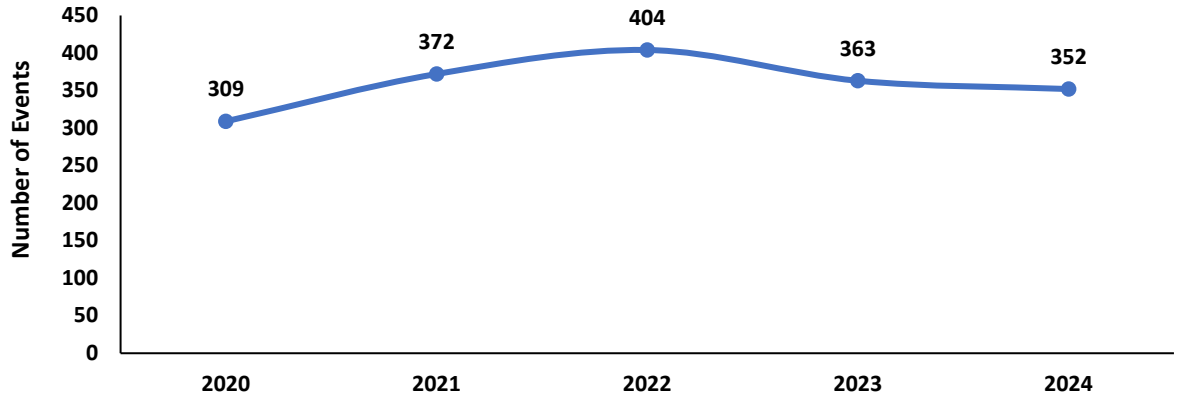
Table 1: Sentinel Event Registry Participation by Health Care Facility Type, 2024.

Facility Type Description	Count of Facility Type	SER Participant	SER Participant Percent
Adult Day Care Facility	26	0	0.00%
Alcohol or Drugs Treatment Facility	56	1	1.80%
Ambulatory Surgical Center	88	44	50.00%
Community Triage Center	1	1	100.00%
Freestanding Birthing Center	1	0	0.00%
Hospice Care Facility	270	13	4.80%
Hospital	50	38	76.00%
Independent Emergency Medical Center	1	0	0.00%
Individual Residential Care Home	118	1	0.80%
Intermediate Care Facility	9	2	22.20%
Medical Detoxification Facility	10	1	10.00%
Narcotics Treatment Facility	16	0	0.00%
Nursing Care in the Home	289	25	8.70%
Nursing Pool	82	19	23.20%
Outpatient Facility	51	13	25.50%
Personal Care Agency	357	11	3.10%
Psychiatric Residential Treatment Center	14	2	14.30%
Recovery Center Facility	3	1	33.30%
Renal Disease Treatment Center	52	29	55.80%
Residential Group Facility	414	16	3.90%
Rural Clinic	20	2	10.00%
Rural Hospital	14	11	78.60%
Skilled Nursing Facility	64	9	14.10%
Total	**2,008**	**239**	**11.90%**

Individual Sentinel Events

In 2024, 73 facilities reported 352 individual sentinel events, a decrease in reported events from the previous three years (Figure 1).

Figure 1: Individual Sentinel Events Including Non-Natural Deaths, 2020-2024.



Of the 352 events in 2024, 17 were non-natural deaths, which are included in the summary below, and are not considered an event by the National Quality Forum.

The number of facilities reporting individual events has decreased from the previous years, from 81 for 2023 to 73 in 2024, representing roughly 4% of the total facilities expected to participate.

Table 2: Individual Sentinel Events Reported by Health Care Facility Type, 2024.

Facility Type Defined	Count of Facilities SER Participation	Non-Natural Deaths	Count of Facilities with Individual Events	Count of Sentinel Events
Ambulatory Surgical Center	44	2	12	18
Hospice Care Facility	13	0	1	6
Hospital	38	5	30	238
Individual Residential Care Home	1	1	1	0
Medical Detoxification Facility	1	1	1	0
Nursing Care in the Home	25	1	5	4
Outpatient Facility	13	0	2	2
Personal Care Agency	11	0	1	1
Psychiatric Residential Treatment Center	2	0	2	16
Renal Disease Treatment Center	28	2	4	4
Residential Group Facility	16	2	3	10
Rural Clinic	2	1	1	0
Rural Hospital	11	2	8	31
Skilled Nursing Facility	9	0	2	5
Total	**238**	**17**	**73**	**335**

Data reported as an individual sentinel event must meet the definition as classified by the National Quality Forum (NQF). In 2024, just over 32% were falls (Figure 2), a decrease from 2023, at 40%, followed by pressure ulcers at 22.9% in 2024 compared to 2023's 20.6% of the reports. For the entire list of categories, type of events, and ranks see the Appendix. Falls and pressure ulcers continue to be the leading events from year to year (Figure 3).

Figure 2: Sentinel Events by Type, 2024.

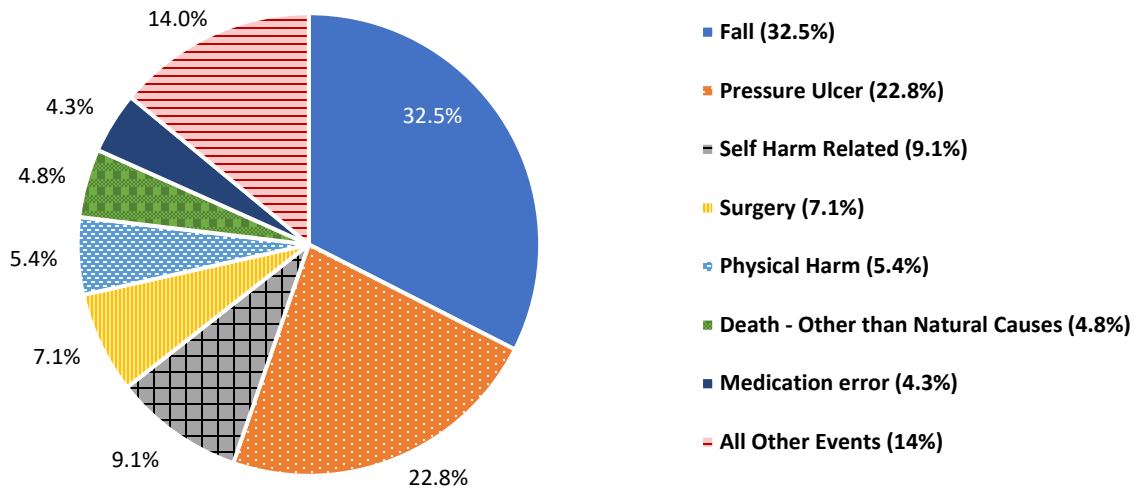
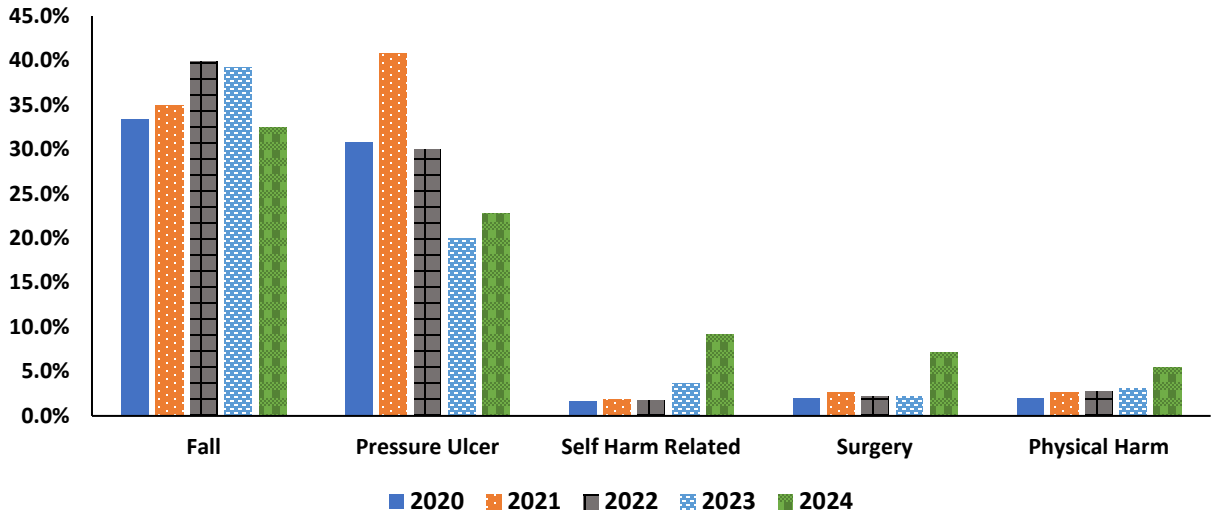


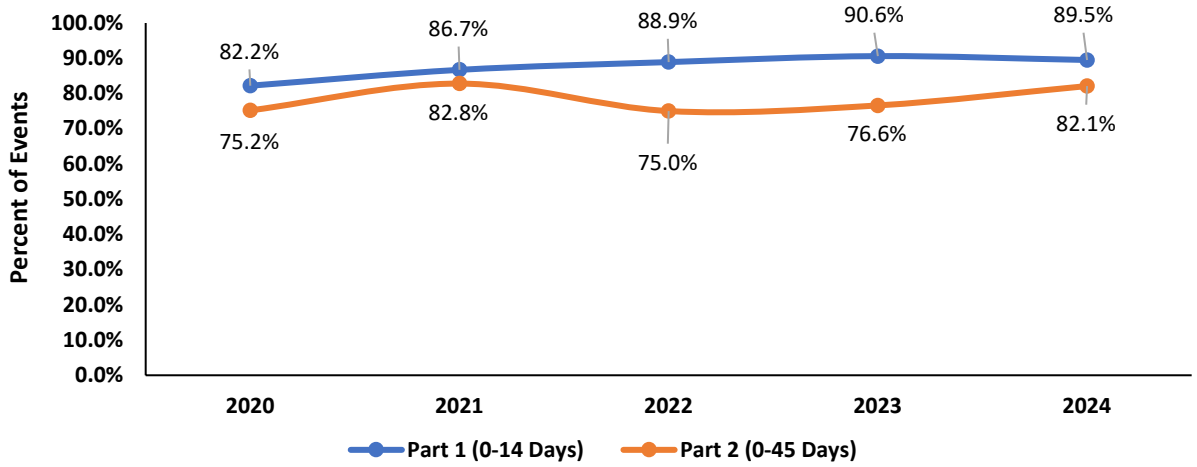
Figure 3: Individual Sentinel Events by Type and Year, 2020-2024.



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 (notification). Part 2 is required to be submitted within 45 days of notifying the Sentinel Events Registry of the event (analysis).

In 2024, just under 90% of the Part 1 events were reported in this proper timeframe, which is down incrementally from nearly 91% in 2023. For Part 2, 82.1% of the events were reported in the proper timeframe, which is slightly up from an adjusted 76.6% in 2023. The timeframe of reporting compliance has varied over recent years (Figure 4). Part 2 is not optional; however, facilities do not always report.

Figure 4: Individual Sentinel Events, Reported in the Expected Timeframe by Part, 2020-2024.



Annual Summary Reports

Annual Summary Reports (ASR) are completed once a year, and all health care facilities are required to report even if no sentinel event occurred. The ASR includes information for all the various sentinel events that occur in a facility and include reporting related to patient safety meetings and patient safety plans for all medical facilities.

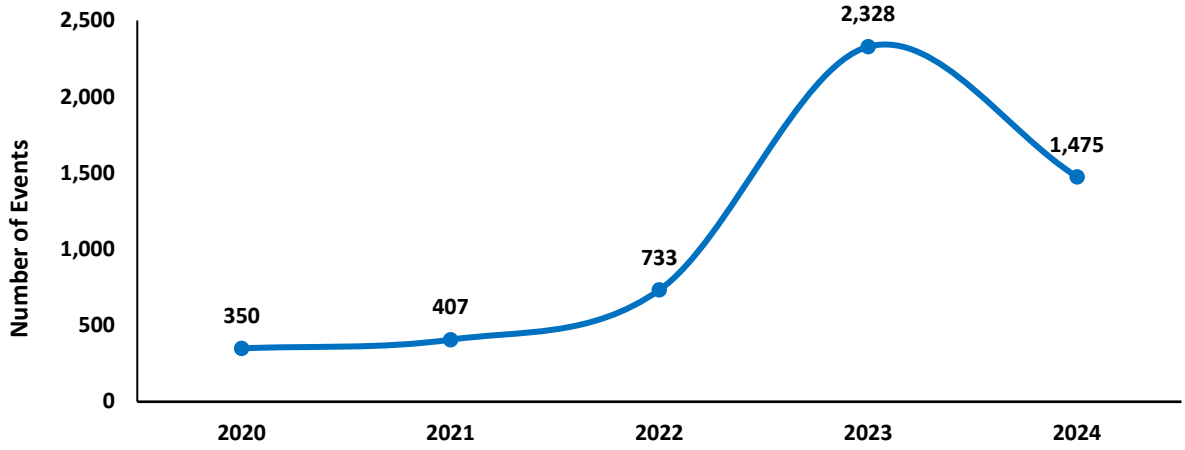
There are 2,008 facilities licensed by HCQC in 2024 compared to 1,828 in 2023. All health facilities are required to report sentinel events as they occur through the individual event forms and should be included in the annual summary submitted each year, by March 1st covering for the preceding year. In 2024, 224 met this requirement (11.1%) compared to 2023 at 11.3%, whereas 1,784 facilities did not report in 2024, which represents nearly 89**%** of the facilities. This is not a significant change from previous years. Table 3 below shows the show the participation for facilities in 2024.

Table 3: Annual Summary Report Counts, 2024.

Event Type	N.	%
Total Facilities Licensed by HCQC	**2,008**	
Facilities that Filed the Annual Report	224	11.1%
Facilities that Did Not File the Annual Report	1,784	88.9%
Of Those that Did Report (n=224)		
Had No Sentinel Events	155	69.2%
Had 1 Sentinel Event	21	9.4%
Had More than 1 Sentinel Events	48	21.4%

With the ASR, facilities can report multiple events that occurred during the reporting year. In Table 3 (above), 48 facilities reported more than one event in 2024. There was one facility that had never reported before that reported a larger than expected number of restraint related events causing the number of events to increase significantly in 2024, yet less than 2023 (Figure 5).

Figure 5: Annual Summary Report of Events by Year, 2020-2024.



Counts from past years may not match this report because some facilities still file an Annual Summary report past the reporting deadline and past the date for inclusion in the current report.

Hospitals have the most consistent reporting to the SER out of all facility types. Of the 64 total hospitals and rural hospitals licensed by HCQC, 49 (77%) completed the Annual Summary Report, a slight decrease from 2023. The combined events reported by these hospitals make up 66% of all the events reported in summary, compared to 2023 at 11%. This is due to a single facility reporting 528 events related to the use of restraints (Table 4).

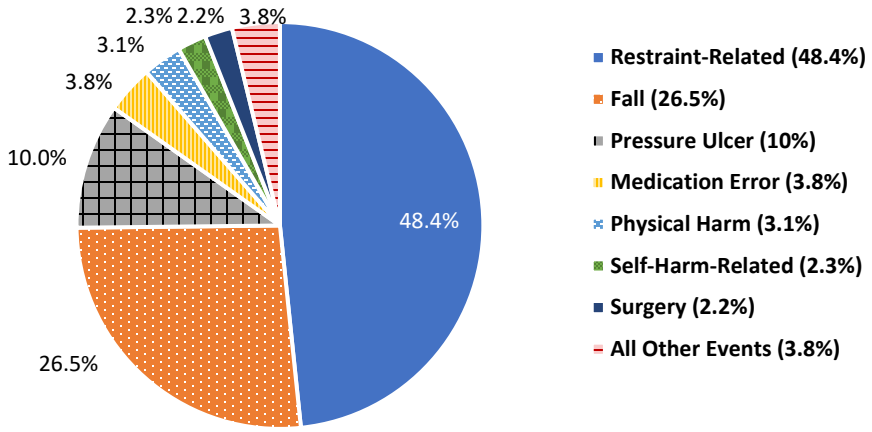
Table 4: Annual Summary Report Counts by Facility Type, 2024.

Facility Type Defined	Count of Facilities Reported	Non-Natural Deaths	Count of ASR Events
Adult Day Care Facility	0	0	0
Alcohol or Drugs Treatment Facility	1	0	0
Ambulatory Surgical Center	37	1	30
Community Triage Center	1	0	0
Freestanding Birthing Center	0	0	0
Hospice Care Facility	13	0	48
Hospital	36	4	939
Independent Emergency Medical Center	0	0	0
Individual Residential Care Home	1	0	0
Intermediate Care Facility	1	0	46
Medical Detoxification Facility	1	0	89
Narcotics Treatment Facility	0	0	0
Nursing Carre in the Home	25	1	81
Nursing Pool	19	0	0
Outpatient Facility	11	0	5
Personal Care Agency	12	0	9
Recovery Center Facility	1	0	0
Renal Disease Treatment Center	29	0	4

Facility Type Defined (continued)	Count of Facilities Reported	Non-Natural Deaths	Count of ASR Events
Residential Group Facility	14	0	171
Rural Clinic	2	0	0
Rural Hospital	11	2	29
Skilled Nursing Facility	9	0	5
Total	**224**	**8**	**1,456**

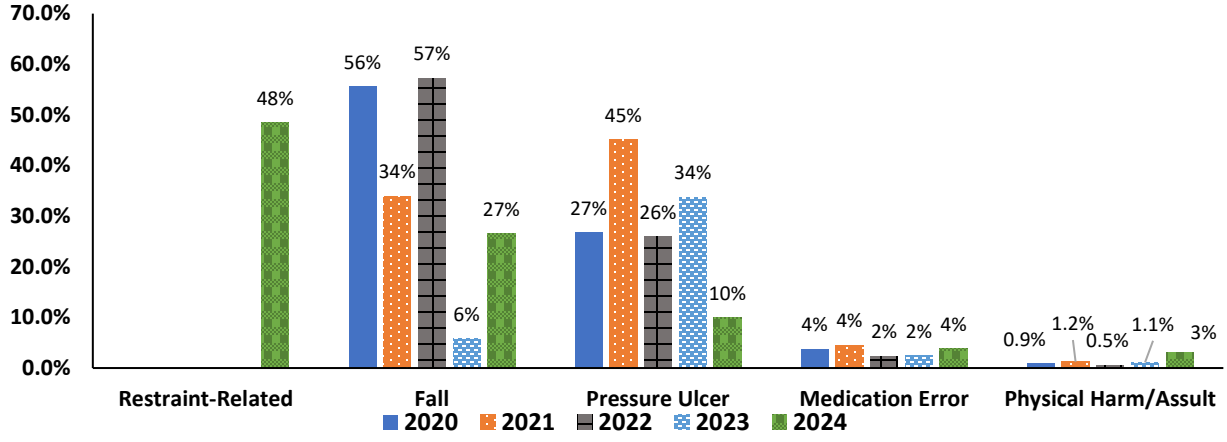
Data reported as an ASR event are defined by the National Quality Forum (NQF) as reportable. In 2024, 48.4% of the events were restraint-related (due to 1 facility reporting 528 incidents), followed by falls at 26.5% of the reports (Figure 6). For the entire list of categories, type of events, and ranks see Appendix. As shown in Figure 7, falls and pressure ulcers continue to be the leading event reported each year.

Figure 6: Annual Summary report by Type of Events, 2024.



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

Figure 7: Annual Summary Report by Type of Events and Year, 2020-2024.



When the facilities submit events, they can include narrative about lessons learned. The following insights, drawn from these narratives, are shared to support other facilities in navigating similar situations in the future.

- ❖ All paperwork must be cross-examined to ensure it all matches before hand-off.
- ❖ Recognize when distractions are present and take the 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.

Patient Safety Committees

As a component of the Annual Summary Report, medical 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 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. Facilities that have fewer than 25 employees and contractors must establish a patient safety committee and meet at least once every calendar quarter. In Table 5, close to 83% of the facilities that reported the ASR did conduct patient safety meetings at the expected intervals, slightly lower than in 2023.

Table 5: Number of Facilities that Reported Having Patient Safety Committees Meetings, 2024.

Monthly/Quarterly	N.	%
Yes	185	82.6%
No	36	16.1%
Did Not Report	3	1.3%
Total	224	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. The Patient Safety Plan's electronic form must be Americans with Disabilities (ADA) compliant.

For 2024, 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 Sentinel Events Registry, either individual events, or the annual summary report has remained steady from year to year with a small increase or decrease of the required facilities reporting each year (11% to 13% in recent years). 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: Individual Sentinel Events by Category, and Event, 2024.

Category	NQF – Event Code	N.	%
Fall	4E - Fall	114	32.4%
Pressure Ulcer	4F - Pressure Ulcer (Stage 3, 4 or Unstageable)	81	23.0%
Death - Other than Natural Causes	8 - Death - Other than Natural Causes	17	4.8%
Physical Harm	7D - Physical Assault	16	4.6%
Self-Harm-Related	3C - Suicide - Attempted	13	3.7%
Self-Harm-Related	3C - Self-Harm	12	3.4%
Medication Error	4A - Medication Error (Wrong Time)	10	2.8%
Surgery	1C - Procedure Complication	9	2.6%
Elopement	3B - Elopement (Disappearance)	7	2.0%
Surgery	1D - Unintended Retained Foreign Object	7	2.0%
Burn	5C - Burn	6	1.7%
Surgery	1A - Surgery (Invasive Procedure) On Wrong Site	6	1.7%
Intra- or Post-Operative Death	1E - Intra- or Post-Operative Death	5	1.4%
Self-Harm-Related	3C - Self Harm - Attempted	5	1.4%
Sexual-Related	7C - Sexual Assault	5	1.4%
Restraint-Related	5D - Use Of Physical Restraint	4	1.1%
Sexual-Related	7C - Sexual Abuse	4	1.1%
Device	2B - Device Failure	3	0.9%
Failure to Communicate	4I - Failure To Communicate (Other)	3	0.9%
Gas	5B - No Gas From System Designated for Gas Delivery	3	0.9%
Medication Error	4A - Medication Error (Wrong Dose)	3	0.9%
Physical Harm	7D - Physical Assault - Attempted	3	0.9%
Surgery	1C - Wrong Surgery (Invasive Procedure) Performed	3	0.9%
Use of Contaminated	2A - Use Of Contaminated Device	3	0.9%
Failure to Communicate	4I - Failure to Communicate Pathology Test Result	2	0.6%
Pregnancy	4C - Maternal Low Risk Pregnancy Delivery	2	0.6%
Self-Harm-Related	3C - Suicide	2	0.6%
Medication Error	4A - Medication Error (Wrong Preparation)	1	0.3%
Medication Error	4A - Medication Error (Route Of Administration)	1	0.3%
Sexual-Related	7C - Sexual Abuse - Attempted	1	0.3%
Use of Contaminated	2A - Use of Contaminated Drug	1	0.3%
Total (Percentages may not add up to 100% due to rounding)		**352**	**100%**

Table 2A: Annual Summary Report Events by Category, and Event, 2024.

Category	NQF – Event Code	N	%
Restraint-Related	5D - Use of Physical Restraint	705	48.2%
Fall	4E - Fall	386	26.4%
Pressure Ulcer	4F - Pressure Ulcer (Stage 3, 4, or Unstageable)	79	5.4%
Pressure Ulcer	4F - Pressure Ulcer (Stage 1 or 2)	66	4.5%
Physical Harm	7D - Physical Assault	42	2.9%
Elopement	3B - Elopement (Disappearance)	29	2.0%
Medication Error	4A - Medication Error (Wrong Dose)	19	1.3%
Medication Error	4A - Medication Error (Wrong Drug)	18	1.2%
Surgery	1C - Procedure Complication	17	1.2%
Self-Harm-Related	3C - Suicide - Attempted	15	1.0%
Medication Error	4A - Medication Error (Wrong Time)	14	1.0%
Self-Harm-Related	3C - Self-Harm	11	0.8%
Surgery	1D - Unintended Retained Foreign Object	8	0.5%
Death - Other than Natural Causes	8 - Death - Not Natural Causes	8	0.5%
Surgery	1A - Surgery on Wrong Site (Body Part)	7	0.5%
Intra- or Post-Operative Death	1E - Intra- or Post-Operative Death	5	0.3%
Self-Harm-Related	3C - Self-Harm - Attempted	4	0.3%
Device	2B - Device Failure	3	0.2%
Self-Harm-Related	3C - Suicide	3	0.2%
Medication Error	4A - Medication Error (Wrong Patient)	3	0.2%
Specimen-Related	4H - Specimen ID Error	3	0.2%
Burn	5C - Burn	3	0.2%
Sexual-Related	7C - Sexual Assault	3	0.2%
Physical Harm	7D - Physical Assault - Attempted	3	0.2%
Failure to Communicate	4I - Failure to Communicate (Other)	2	0.1%
Gas	5B - No Gas from System Designated for Gas Delivery	2	0.1%
Sexual-Related	7C - Sexual Abuse	2	0.1%
Use of Contaminated	2A - Use of Contaminated Device	1	0.1%
Medication Error	4A - Medication Error (Route of Administration)	1	0.1%
Pregnancy	4D - Neonate Low Risk Pregnancy Delivery	1	0.1%
Gas	5B - Wrong Gas	1	0.1%
Total (Percentages may not add up to 100% due to rounding)		**1,464**	**100%**