# DISCLAIMER

Electronic versions of the exhibits in these minutes may not be complete.

This information is supplied as an informational service only and should not be relied upon as an official record.

Original exhibits are on file at the Legislative Counsel Bureau Research Library in Carson City.

Contact the Library at (775) 684-6827 or library@lcb.state.nv.us.

# Sentinel Event Registry Analysis

## Overview

Requires the Health Division to create a central repository for the collection of sentinel events from hospital (NRS 449.012 and 449.0151) obstetric centers (NRS 449.0151) and surgical centers for ambulatory patients (NRS 449.0151 and 449.0155) **Attachment A**. The data are collected and aggregated with identifiers removed and transmitted to the quality improvement organization, who will analyze and report sentinel event trends. The Health Division serves as a clearinghouse for the aggregated information, with the primary role of the Division maintaining a Sentinel Event Registry.

## Health Division Responsibilities

1). Collect and maintain reports received of sentinel events. (**Sec. 29**)

   a.) Make record of sentinel event, medical facility corrective action plan and contributing factors of sentinel event. (**Sec. 30**)

   b). Compile and aggregate data and remove identifiers for medical facility, patient and medical provider. **(Sec. 30)**

   c.) Transmit edited data to the quality improvement organization. **(Sec. 30)**

   d.) Function as a clearinghouse for the quarterly reports complied by the quality improvement organization. **(Sec. 31)**

2). Contract with a quality improvement organization (42 CFR 400.200) **Attachment B**.

3). Administrator shall adopt regulations as the administrator determines necessary to carry out the provisions of **NRS 439 Sections 19 to 39**. This will be essential to delineating polices, procedures and processes for the implementing AB1. **(Sec. 39)**

## Quality Improvement Organization Responsibilities

1). Analyze sentinel events. **(Sec. 30.1)**

SUBCOMMITTEE K-12/ HUMAN RESOURCES
DATE: 2-13-03 EXHIBIT D
SUBMITTED BY: SYLVA, HEALTH DIV, DHR

2). Report quarterly to the Health Division findings regarding the analysis of aggregated trends of sentinel events. **(Sec. 30.3)**

**Reporting Facilities Responsibilities**

1). Designate a patient safety officer established within the medical facility.

a). Serve on patient safety committee.

b). Supervise the reporting of all sentinel events.

c). Ensure patient safety related to alleged sentinel event.

d). Report to the patient safety committee any action taken to ensure patient safety related to alleged sentinel event.

e). Report to the Health Division within 13 days after notification, the time, date and brief description of sentinel event.

f). Report to the designated representative of the facility for the notification of patients within 13 days after notification, the time, date and brief description of sentinel event.

2). Designate a representative of patient notification.

a). Notify any patient within 7 days of those that have been involved in a sentinel event. **(Sec. 32)**

3). Designate a Patient Safety Committee. **(Sec. 36)**

a). Must be composed of one member of medical, nursing and pharmaceutical staff of the medical facility and one member of the executive or governing body of the medical facility.

b). Committee shall meet monthly and report at least once quarterly to the executive or governing body.

c). Committee will review the reports from the patient safety officer and evaluate actions taken on all sentinel events. In addition, review and evaluate the quality of measures carried out by the medical facility.