Trigger Tool Review Process

A modern method to measure adverse events

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my hospital

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Swan Hill District Health

Smallest Cat B Hospital

68 acute care beds

- **Medical & Surgical**
- **Emergency**
- **Dialysis**
- **Chemotherapy**
- **Theatre & DPU**
- **Midwifery**

76 aged care beds

Community services

Health promotion

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Traditional methods to measure adverse events

- Focused on incidents of harm
  - Voluntary incident reporting
  - Consumer feedback
  - LAOS

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Issues with traditional methods

- Voluntary incident reporting
  - Only 10 – 20% all incidents reported
  - 90% reported incidents result in no harm

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Issues with traditional methods

- Consumer feedback
  - Relies on feedback being provided
  - Often subjective

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Issues with traditional methods

- LAOS
  - Focused on errors not harm
  - Often significant delay until review
  - Does not consider local concerns
  - Individual reviewer

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IHI Trigger Tool Review Process

- Focus on delivery of care only
- Focus on harm whether preventable or not
- Categorises level of harm
- Review of medical histories by consistent team
- Review charts for presence of triggers only initially
- Certain exclusion criteria

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Local Adaptations

- Range of triggers identified
  - Any code or arrest
  - Readmission within 30 days
  - Unplanned return to theatre
  - Narcan (Naloxone use) outside theatre or ED
  - Representation to ED within 48 hours
  - Patients receiving thrombolysis beyond target time
  - Transfer to higher level of care

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The Process

- 10 charts reviewed per month
- Primary reviewers examine charts to identify
  - Adverse events whether harm occurred or not
  - Also identify issues that could have led to adverse event
- Record notes on each chart

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Categories of harm

- E - temporary harm requiring intervention
- F - temporary harm requires hospitalisation
- G - permanent harm
- H - interventions required to sustain life
- I - patient death

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The Process

- Develop summary sheet of all findings
- Discuss findings with Physician reviewer
- Discuss findings with appropriate manager/s
- Develop action plan
- Team meeting to discuss findings

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Trigger Tool Review record
May review

UR	LOS	Trigger	Adverse Events	VMO	HMO	Primary Diagnosis	Category of Harm	Comments	Issue categories
1234	3 days	Transfer to higher level of care	Cardiac Arrest	Jack	Finn	Chest Pain	F	Inadequate documentation Inadequate monitoring Delayed request for medical review	Clinical Care

Trigger Tool Review Meeting record
May review

UR	Issues identified	Planned actions	Person responsible
123456	Inadequate documentation	Clinical notes printed and added to patient history Remind staff of need to ensure documentation is complete	Nurse Betty
	Inadequate monitoring	Support ACN to conduct case study for presentation to staff group	Clinical Support Nurse
	Delayed request for medical review	Develop & promote use of Medical Alert System	Director of ED

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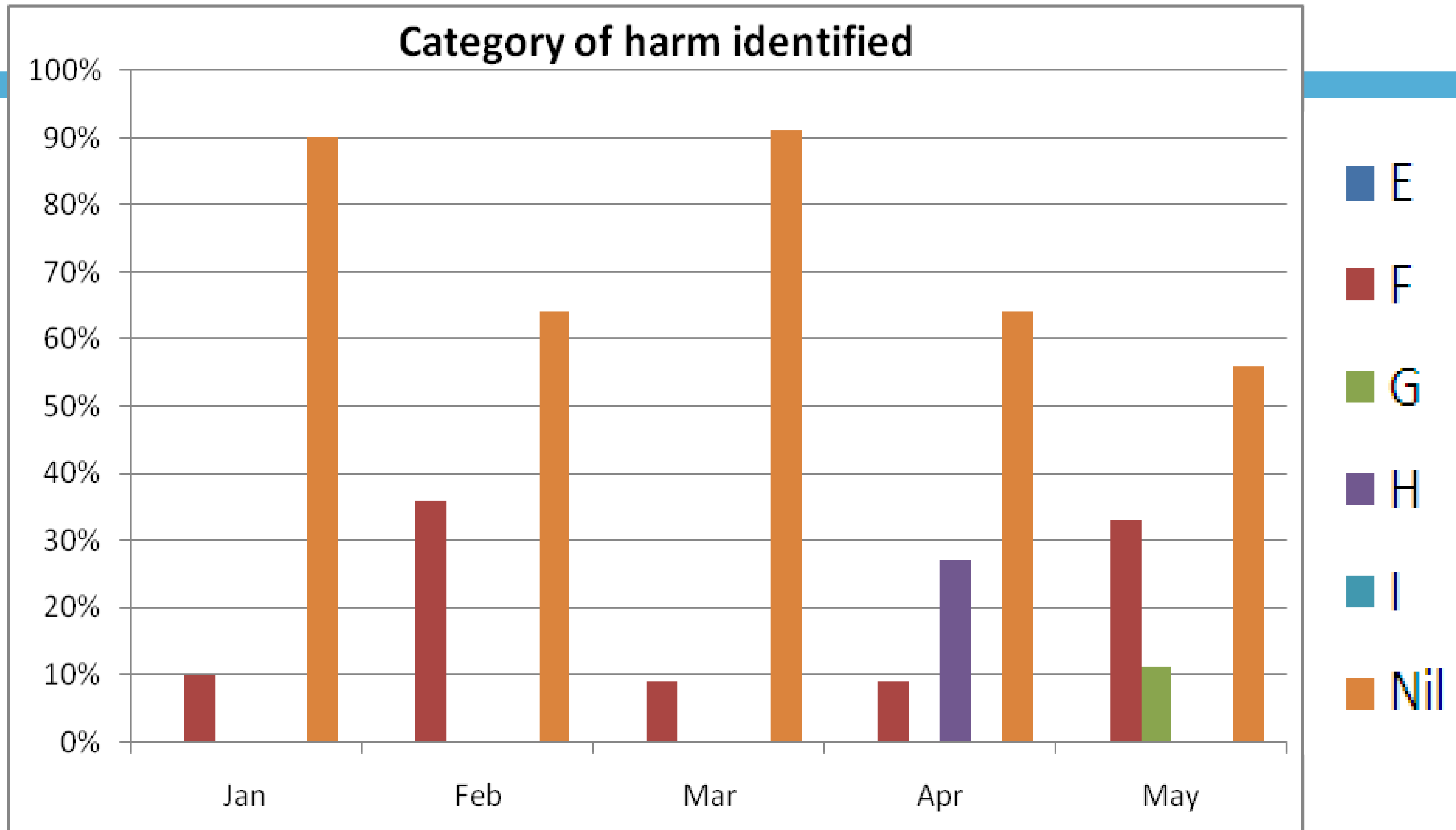
Snapshot of results



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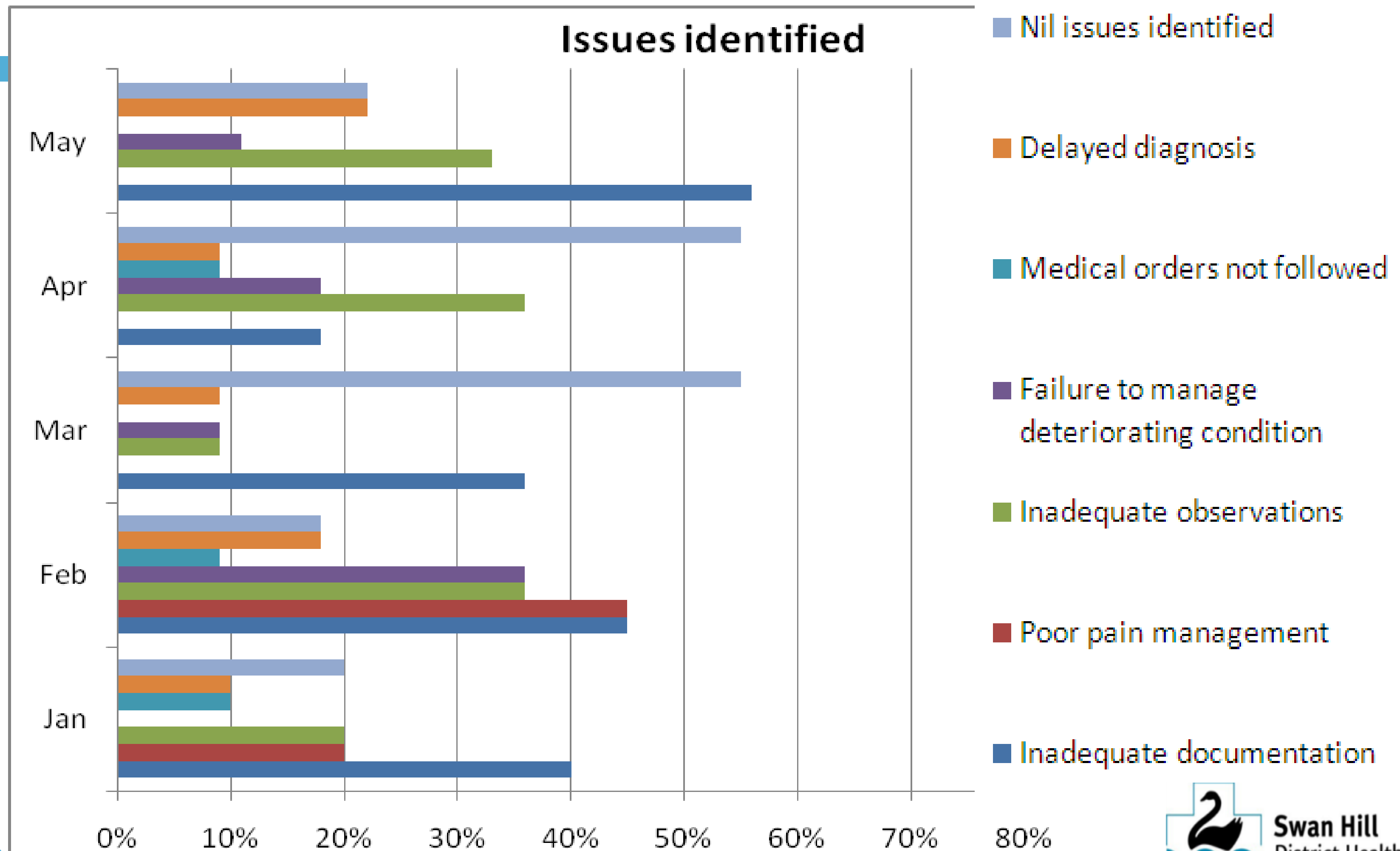
Snapshot of results



Achievements to date

- Improved documentation
- Scheduled reviews of episodes of care by clinical staff
- Dedicated education sessions
- Rejuvenation of Medical Alert System
- Regular audits of identified areas of concern

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“The only thing they need to change in this organisation is the gowns”

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