TRIGGER TOOL

RCGP LEARNING

INTRODUCTION

What is it?	Why would I do it?	How is it done?
• System of rapid retrospective note review. • The period between four months and one month before the review date should be studied.	• Allows clinicians to detect episodes of harm/patient safety incidents (PSIs) and patterns of error which might be occurring in their practices.	• Randomly select 25 records from your practice – this might be from all records, or from a sub-group e.g. patients aged ≥ 75. • Spend no more than five minutes per patient in the initial look for PSIs. • More detailed instructions for the trigger tool are here.

TRIGGERS

What is a trigger – principles.	List of triggers.
• Seven examples are given on the form, with space for personalised ones to be added if wished. • Not every trigger will be a PSI. • A patient may have multiple triggers, but possibly no PSIs.	• Three or more consultations in any period of seven consecutive days. • New significant diagnosis. • New allergy code added. • Repeat oral or injectable medicine discontinued. • Out of hours or emergency department attendance. • Emergency hospital admission. • Haemoglobin < 100 g/L.

PATIENT SAFETY INCIDENTS (PSI)

PSI definition.	PSI examples.	I've found a PSI – what now?

• Any unintended or unexpected incident which could have led, or did lead, to harm for one or more patients receiving healthcare.	• Missed monitoring for existing medications, found when reviewing records to add a new medication.
	• Repeated presentations not leading to reconsideration of the possible diagnosis.
	• Diagnosis delayed due to administrative errors.
		• Allocate a number 1 – 4 for severity and preventability.
		• Prioritise the PSIs with higher scores for initial review.
		• For each PSI:
		  ○ Describe the PSI on the form and reflect on it.
		  ○ Consider what actions were taken while the review was done and what are the appropriate next steps.
		• Record this on the form.

REFLECTION

Why?	How?	Follow-up.

• Reflection is a key tenet of appraisal, revalidation and patient safety – only by reflecting on PSIs can we prevent them from happening again.	• Various reflection models available in resources section of this toolkit.
	• A simple one is as follows:
	  ○ "What?" (What happened?).
	  ○ "So what?" (Why does it matter?).
	  ○ "Now what?" (What can I do to change things?).
		• Use the learning points section on the form to document any personal or practice learning needs or other points.
		• Consider discussing these at a practice meeting, or more widely in the local area (e.g. at PCN/ICB level) if they have relevance outside the practice.