Instructions for the Adapted NES Trigger Tool

Introduction

The trigger method is a system of rapid retrospective note review to allow clinicians to detect episodes of harm and patterns of error which might be occurring undetected in their practices. For the purposes of the NIHR toolkit we would like GPs or GP trainees to complete the tool. Each reviewer should complete 25 records – understanding and familiarity with the tool improves as one reviewer learns to use it.

Selecting a sample of patient records to review

Randomly select 25 records from all the patients in your practice for example choosing patients aged 75 years and older. You might like to keep an internal record of which patients were included so you don't screen their information again if you continue using the tool in the future. Please do not record patient identifiable data on the data collection form. Only 3 months of trigger data per patient are required; consider the period between **4 months and 1 month prior to the review date** in order to allow time for patient safety incidents (PSIs) to have occurred.

Practical tips about 'triggers'

It is quite possible for a single patient record to generate multiple triggers, or indeed the same trigger may come up more than once, e.g. two hospital admissions during the three month review period. On the record sheet, please keep a tally for *each* trigger every time it is detected in each record. We are collecting data on the frequency of triggers in order to better understand how commonly these events occur. The triggers do not necessarily represent PSIs; they merely indicate that a PSI may have occurred and should alert you to look in more detail at that part of the record. With a little practice most reviewers very quickly develop their own 'system' to screen their electronic health records to detect these triggers. It is helpful to review sections of the clinical record in a systematic manner.

Clarification of a few common triggers:

- **3 or more consultations in 7 days:** What is a 'consultation'? Consultations are any face-to-face, home visit or telephone contact with patients by any member of the practice team. Administrative and 'coding' entries in medical records are not considered consultations.
- **New significant diagnosis:** Any newly coded diagnosis which, in your professional opinion you consider a 'high priority' or 'high severity', e.g. DVT, cancer, diabetes mellitus
- **OOH/A&E attendance:** Record each contact in the three month period of review as a trigger. However, if more than one contact occurs in a single 'journey', then this should be counted as only one trigger, e.g. a patient attends OOH and is transferred to A&E would be recorded as one trigger.
- **Emergency Hospital admission:** Record this as a 'trigger' even if the patient was admitted to hospital via A&E

Patient Safety Incidents (PSIs)

PSIs include 'near misses', incidents with the potential for harm as well as actual harm. It is the preferred term and includes other terms such as 'adverse incident' and 'adverse event'. In other words, PSIs are essentially anything that you would not want to happen to a patient that might be the responsibility of the healthcare system. Reviewers sometimes detect PSIs incidentally while reviewing records, without any apparent link to a trigger. For example, missed monitoring opportunities for existing medications found when reviewing records for a 'new repeat medicine' trigger. This is completely acceptable and the PSI should still be recorded. Remember, the aim of the trigger review method is to find previously unknown and/or undetected PSIs. The triggers are only a means to this end. Sometimes you have to think creatively to recognise a PSI.

For research purposes we would also like to know which trigger alerted you to the PSI, in some cases it may be more than one trigger and in others no trigger may be involved. Record the trigger number as per the 'Trigger Information' section of the form.

What if you 'find nothing' in the review, despite applying the method correctly? This does occur in around 10% of trigger reviews. However, it would be very unusual for this to happen with each and every review you do. Some would argue that you didn't find 'nothing', but that you found evidence of safe, high quality care.

Priority scoring

Once you have identified a PSI then you need to assess its priority to help you prioritise the order in which the patient safety incidents may be considered for action. This is obtained by calculating the severity scale of the incident (between 1-4) and adding it to the preventability scale (between 1-4). Incidents with higher priority scores should arguably be considered first, although this remains at the discretion of the reviewer. Remember that the severity and preventability judgements and scores are subjective.

Reflecting on the review process

Interestingly, many reviewers don't realise just how much they are actually 'doing' during reviews; completing the 'actions during review' section of the final table gives you an idea of the immediate return on your investment of effort and time.   To get the most out of the tool reflect on **learning points** and **learning needs** at the end of the review, particularly if any patterns or themes emerge from the PSIs. These two issues can be considered at different levels: individual (e.g. professional, personal); practice level; professional group; primary care, etc. Maybe consider questions such as:

What did you learn during or as a result of the review - about your own practice, about your patients and about record keeping?