Let's Talk Triggers

Issue 1 – August 2014

Hello and kia ora, everyone.

This is the first issue of *Let's Talk Triggers*, our new-look newsletter which will be published quarterly with updates, trigger tool tips, featured articles and other items on patient safety. *Gillian Robb*

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Using data for improvement

Many DHBs now have sufficient information to undertake some meaningful analyses and identify themes for improvement. The challenge is to translate this into action. Lakes DHB is well on the way to getting some improvement projects underway.

'GTT has opened our eyes to the importance of clear, concise documentation in clinical notes. It has sensitised us to the fact that recognised side effects or complications of medical interventions all count as 'harm events' from the patient's point of view. After 18 months of data collection we have been able to identify five top areas of harm within the organisation and are now keen to develop robust quality improvement projects to address the problems identified.'

Dr Ulrike Buehner, Clinical Director ICU, Lakes District Health Board

It is worth noting Ulrike's message that recognised side effects or complications of medical interventions are all forms of harm from the patient's point of view, but they typically don't reach the threshold for reporting.

A key advantage of using the GTT is that flagging these types of harm provides insights into the quality and reliability of care processes within a speciality or service area. This can be a useful starting point for conversations with clinicians.

GTT in Southern Cross Hospitals

Southern Cross Hospitals is now involved in the GTT process, having completed GTT training in April. The organisation is planning to implement the GTT across a number of sites and is welcomed as part of the wider GTT network.

National workshop, Ko Awatea – 11 April 2014

It is now just over a couple of months since our workshop in April, which focused on 'Using data for improvement'. The workshop was attended by 50 participants from 11 DHBs.

It was really great to see that many DHBs are now getting significant numbers of events and are starting to analyse their data – and even more exciting that some are now using the data for improvement. This, of course, is the whole point of using the GTT, but it's probably the most challenging aspect for all of us! We had very good feedback about the workshop.

There is so much value in getting together to share information.

Click here for access to the workshop storyboards and presentations.

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Trigger tools in primary care

Primary care practices that are part of the Counties Manukau 'Safety in Practice' collaborative are starting to use a primary care trigger tool to identify patient harm. The methodology being used is based on that used by the Scottish Patient Safety Programme in Primary Care. A set of 10 triggers has been developed for the New Zealand setting. This set incorporates a combination of triggers from the Scottish tool and the triggers developed by Dr Kyle Eggleton in New Zealand.[1]

The approach to using the GTT in primary care is somewhat different to its use in secondary care settings. Because of the nature of general practice, practitioners are directly involved in reviewing their own records. Using the tool provides a direct window into the quality of care, so the links between harm identified and actions taken to improve care are more immediate. As part of the review process, practitioners are encouraged to document any immediate actions taken (eg, updating coding and prescribing) and to plan next steps (eg, make a specific improvement; update a protocol; plan a PDSA cycle). There is less focus on establishing rates of harm in the practice population as a whole, although some practices may choose to do this.

The way trigger tools are used in primary care may stimulate ideas about how the GTT could be applied in the secondary care setting.

1 Eggleton K, Dovey SM. 2014. Using triggers in primary care records to flag increased adverse event risk and measure patient safety at clinical level. *NZMJ* 127(1390).

GTT e-learning course

The GTT e-learning course is in the final stages of development into an online format. The current implementation guide is being modified so it matches and supplements the e-learning course.

We are currently seeking feedback from our reference group on the e-learning course and revised implementation guide. Once final modifications have been made, the course will hopefully be available by the end of August for training new GTT users and as a refresher for current users.

Update on Gill

Gill Robb is leaving Counties Manukau DHB to take up additional work with the Health Quality & Safety Commission, effective from 1 August 2014.

She will continue her role as clinical lead for the GTT programme and will maintain strong links with Counties across both the GTT and the primary care trigger tool.

Please direct all communications to Gill at her Commission email address: **gillian.robb@hqsc.govt.nz**

Trigger tool tips

Florida Classification Tool: Coding each identified patient harm using the Florida subcategories is absolutely essential for analysing data to identify themes for improvement.

Following on from the workshop, some aspects of the Florida Classification Tool have been clarified.

We have now provided an updated list of the subcategories and developed definitions. Many of the subcategory definitions align with the trigger definitions when determining harm, but for some of the subcategories we have added a definition to provide greater clarity when classifying harm.

Key definitions to review:

- IV volume overload/ electrolyte imbalance
- Fall with injury
- Pressure injuries
- Skin tear, abrasions or other breakdown
- Post-op spinal tap headache
- Prolonged post-op ileus

Click here to access the revised Florida Classification list and subcategory definitions.

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Featured article

Kennerly D, Saldana M, Kudyakov R et al. 2013. Description and evaluation of adaptations to the Global Trigger Tool to enhance its value to adverse event reduction efforts. *Journal of Patient Safety* 9(2).

This article outlines ways in which the GTT was adapted to ensure its ongoing sustainability and value to the organisation (in this case, Baylor Health Care).

These adaptations included:

- including only patients with a length of stay of three days or more versus the recommended 24 hours – this increases the likelihood of finding an adverse event
- making a distinction between hospital acquired vs present on admission
- making judgements of preventability
- noting events related to the omissions of care
- using the 'S-B-A' format (Situation-Background-Assessment) to standardise the narrative description of the harm
- using a single reviewer (these are external to the organisation and trained in medical record review which is their work role)
- using an expanded list of subcategories
- developing a set of 'situations and comments' to clarify ambiguities. This is updated regularly as feedback is received.

In New Zealand, we encourage a standard approach across all DHBs. However, given the GTT is for local improvement, minor adaptations can be made to suit the needs of the organisation. Regional collaborations would be a useful forum to discuss ideas and share learning.

On the horizon

Medication safety: High-risk medicines focus in *Open for better care* campaign

The GTT programme will need to align closely with topic 4 of the *Open for better care* campaign as it is focused on medication safety and specifically high-risk medicines. The topic is due to launch in October 2014, and will see the implementation of a breakthrough collaborative on the safe use of opioids in hospital settings.

Harm from opioids has been consistently identified through the GTT, so this is an exciting initiative and one that will be a further catalyst for DHBs to get on board with the GTT programme.

More on this in our next newsletter.

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