Safety in Practice Trigger Tool Submission Form

**Complete and email a copy of this form to** [**audit@safetyinpractice.co.nz**](mailto:audit@safetyinpractice.co.nz) **by 15 March2021**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Reviewer** |  |  | **Name of Practice** |  |
|  |  |  |  |  |
| **Date of Review** |  |  | **Profession** |  |
|  |  |  |  |  |
| **No. of Records Reviewed** |  |  | **Review Period**  e.g. 3/12 |  |
|  |  |  |  |  |
| **What Patient Group did you select records from?** |  | | | |
|  |  | | | |

**Review of Records**

**Please review up to 25 records from the chosen patient group. Tick one box (✓) next to each trigger each time you find it in one of the records.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Trigger**  (A ‘prompt’ that MAY indicate a safety incident) | 001 | 002 | 003 | 004 | 005 | 006 | 007 | 008 | 009 | 010 | 011 | 012 | 013 | 014 | 105 | 016 | 017 | 018 | 019 | 020 | 021 | 202 | 023 | 024 | 025 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [≥2 consultations in 7 days](#Consultations" \o "Multiple consults can be the result of the patient being very unwell, needing review or the treatment not progressing as predicted.  Look for unintended events from other care/treatment that required consultation with others afterwards.) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [New diagnosis of Cancer within 3 months](#Cancer" \o "New diagnosis of cancer within the review period.) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [New allergy/adverse reaction add to PMS](#Allergy" \o "There is an allergy/adverse drug reaction documented through the ‘alert’ system in the PMS within the review period.) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [Cessation of Medication](#CessationMeds" \o "Look for ‘stop’ or ‘discontinue’ of medication and the reason that this was done.  This may be due to factors such as drug interactions, development of side-effects, or medication no longer indicated.  It may also be related to a prescription error. Do not) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [Reduction in Medication](#ReductionMeds" \o "Look for change in the dose of a medication and the reason for the decrease in dose.  This may be due to factors such as change in medication regimen, development of side effects, or drug interactions.) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [Out of Hours/A&E attendance](#Afterhours" \o "Look for the reasons, could indicate for example an inadequate response to GP initiated treatment, incorrect diagnosis, inability to access GP review or deterioration of the patients health.) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [Hospital discharge](#Discharge" \o "Refers to any unplanned (e.g. emergency admission) or planned admission (e.g. elective surgery) during the period of review.  The discharge correspondence and the period just before and after the admission should be screened for the presence of potential p) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [Hb <100](#Hb" \o "Refers to haemoglobin of < 100.0 g/dl recorded during the period of review.  It is a prompt to consider the possibility of a patient safety incident and general care of a patient and does not by itself signify error or harm.) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [eGFR <35](#eGFR" \o "Patients with results outside of range have a greater risk of experiencing an adverse event.  The lab value is only a trigger, so look for evidence of harm.) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [Death within review](#Death" \o "Death during the review period.   ) period |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Incidental Findings**

**Please briefly describe any incidental findings that you have detected.**

**Review Patient Safety Incidents**

**For further clarification see Trigger Tool Guide page 15.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Severity** | **Definition** |  | **Preventability** | **Definition** |
| 1 | Any incident with the potential to cause patient safety incident ( includes where an incident ran to completion without harm, or mitigating action was undertaken which avoided harm, or where insufficient details were available) | 1 | Not preventable and originated external to this practice (secondary care / other provider) . |
| 2 | Mild patient safety incident: inconvenience, further follow-up or investigation to ensure no patient safety incident occurred | 2 | Preventable and originated external to this practice ***OR*** not preventable and originated in this practice. |
| 3 | Moderate patient safety incident: required intervention or duration for longer than a day | 3 | Potentially preventable and originated in this practice. |
| 4 | Prolonged, substantial or permanent patient safety incident, including hospitalization (or death) | 4 | Preventable and originated in this practice. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Anonymised patient number** | **Description of detected patient safety incidents** | **Severity** | **Preventability** | **Priority** |
| ( Example)  006 | Patient prescribed antibiotic to which they were known to be allergic but was recorded incorrectly in the Patient Management System | + =  4  44  + =  + =  + =  + =  + = | | 8 |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Reflection, Action & Improvement**

|  |
| --- |
| **A. Please describe any actions/improvements made DURING the review (e.g. updated coding or prescribing)** |
|  |

|  |
| --- |
| **B. What do you plan to do NEXT as a result of the trigger review findings?** (Use the priority scores to guide you)  Examples might be to develop or update a process or policy, undertake PDSA cycle, undertake Significant Event Analysis or complete an audit |
| **C. Please describe identified individual, professional or practice team learning opportunities:** |
|  |

|  |  |
| --- | --- |
| **Any other comments** | |
|  | |
| **Finally, approximately what length of time (in minutes) did it take you to review all records?** | **Mins** |

**Please email a copy of completed form to** [**audit@safetyinpractice.co.nz**](mailto:audit@safetyinpractice.co.nz)

# 