Trigger Tools
ADE / GTT

Hospital name:

Nelson Marlborough DHB

Presenters: Kath Devine & Gilda McArthur

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Your team

- Gilda McArthur - Clinical Audit Co-Ordinator
- Kath Devine - Clinical Audit co-Ordinator
- Dr Bruce King - Senior Physician
- Rosey Wilson - Medical Services Manager
- Aaron Smith - Clinical Governance Group

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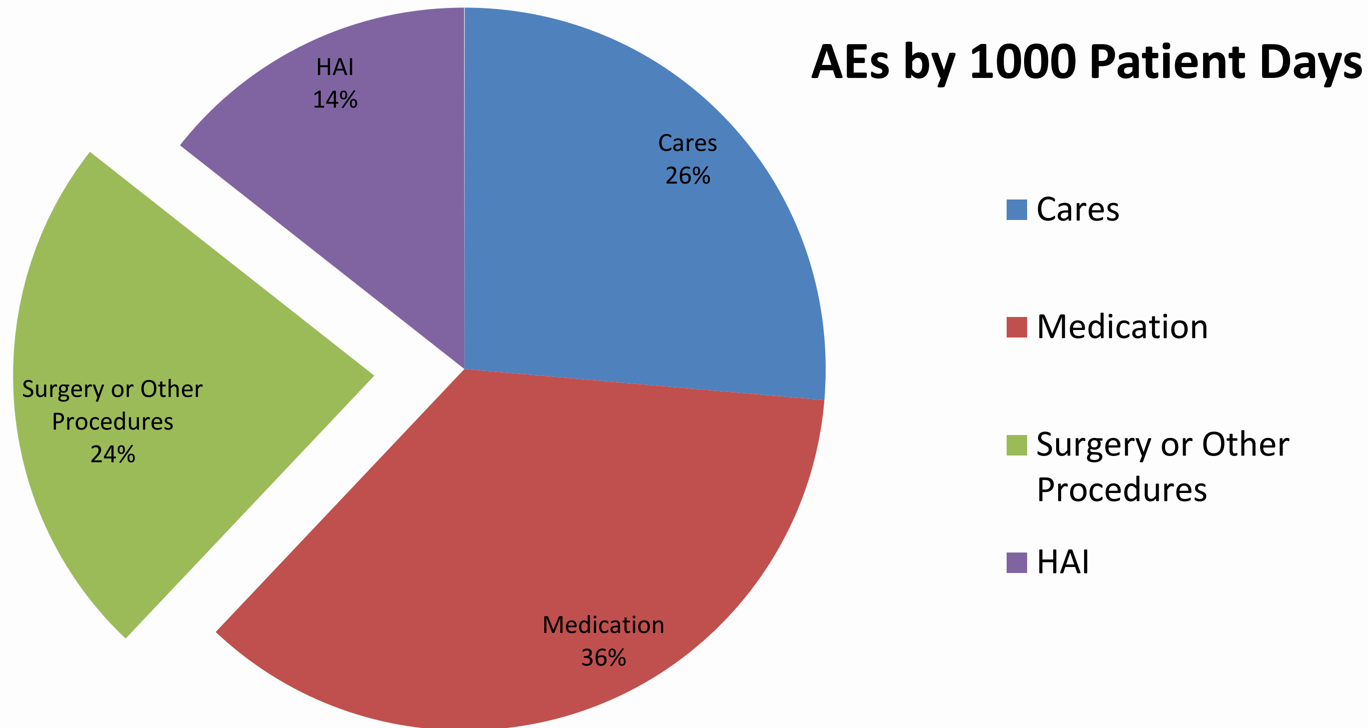
Data Collection Process

- Data collection recorded from October 2012
- 10 clinical notes reviewed & recorded per fortnight
- Data collection as per the IHI guidelines

Translating Data into Action



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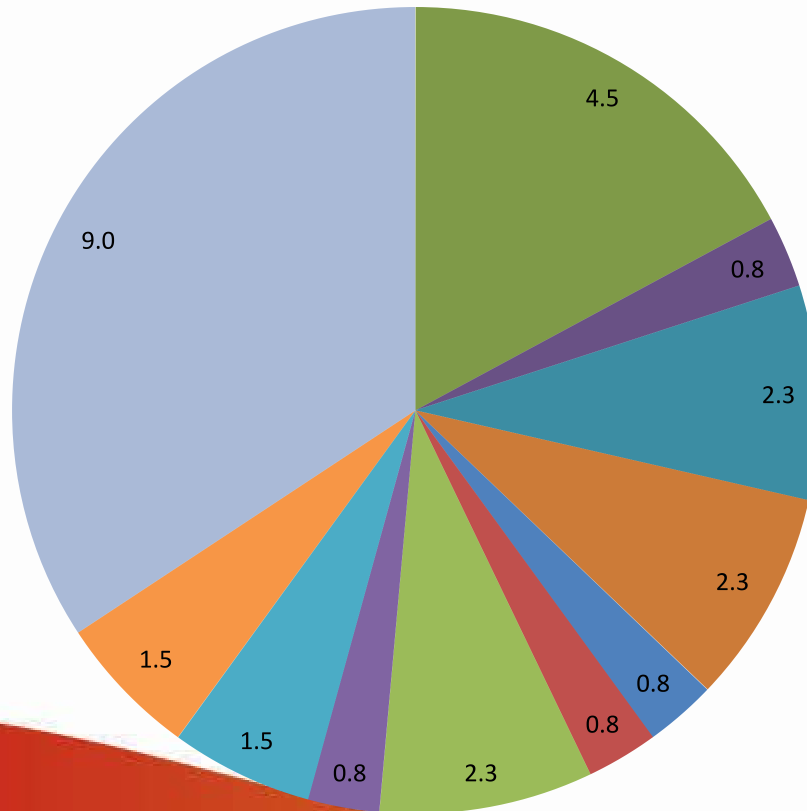
Translating data into action

AE's Per 1000 Pt Days Surgery and other Procedures



- Sub-categories Abnormal bleeding following surgery or procedure
- Sub-categories Cardiac complications related to surgery or procedure
- Sub-categories Complications related to peripheral venous or arterial puncture
- Sub-categories Hypotension/blood loss
- Sub-categories Post-op acute renal failure
- Sub-categories Premature extubation causing respirtory failure
- Sub-categories Prolonged post-op ileus
- Sub-categories Removal/retained foreign body
- Sub-categories Removal, injury or repair of organ
- Sub-categories Respiratory complications related to surgery or procedure
- Sub-categories Other

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Themes so far

- Medication related Hypotension
- Post Operative Pneumonias
- Medication Related Renal Insufficiency
- Admissions for post op infection from other facilities
- Fall with injury

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- We had significant challenges as we worked to incorporate the Melbourne Data base within our system.
- After a period of time we changed to a simple excel spreadsheet incorporating the Florida classification.
- We had challenges deciding which sub-classification certain AE's fitted into E.g. Surg Patient, post op infection, HAI – does this fall under care module-HAI or surgical model-other?

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Lessons Learnt

- Our data records for the first quarter identified a lot of triggers and harms, our 2nd and 3rd quarter - less as we became more consistent with our categorization and use of the GTT.

- Initially we became ‘trigger focused’ focusing on the trigger rather than a possible harm, then later found it was easy to become complacent with each time we recorded for eg. another ‘M10’ (anti-emetic use) in the data collection phases.

Lessons Learnt continued:

- Omissions : we added them onto our collection tool as they became apparent for follow up within the appropriate departments

- Our Prime Learning is the value of early and robust support from information systems departments.

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Ideas for Sharing

- Become really familiar with your collection tool and fill out all of the boxes to save you having to revisit the clinical records. **
- Collecting data alone is not helpful until you have a spreadsheet/tool to enter it into as this shows the gaps in your data collection & aids specifically which data is important to record.
- Provide education on the GTT to relevant departments to avoid misunderstandings in your organization eg. You need at least a year (or more) data before trends start to become apparent.

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Improvement Projects Undertaken

- Currently our Clinical Governance Group is looking at data trend analysis and responses We also work closely with our Quality Team, Senior Management and other departments e.g. Pharmacy to look at trends and pathways for improvements going forward.

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Future developments

- Quality improvement projects…we have taken our findings to our team to analyse and respond appropriately. Follow Up is then delegated to various team members.
- Expanding database…this is a work in progress
- Working more closely with the review team is our focus for establishing feedback loops to all areas.

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