Working with SHAs case study: Using the global trigger tool in an integrated safety system

Overview

In 2009, the NHS South West began advocating the use of the Institute for Healthcare Improvement's (IHI) global trigger tool, as part of their Quality and Patient Safety Improvement programme. Senior nursing staff at Royal United Hospital Bath NHS Trust saw its potential and decided to formally embed the tool within their practices. It is now a core part of the hospital's safety system and the assistant director of nursing, who leads the work, says it is essential for identifying and acting on hospital-wide issues.

Details

Each month, up to ten clinicians meet to review 20 sets of notes, of patients discharged in the previous month. The group includes senior nurses, a consultant nurse, acute physicians, medical director and an anaesthetist. Each uses the global trigger tool to review a selection of patient notes. If a harm event is identified, the notes concerned are reassessed by another member of the group. Any emerging issues are then emailed to lead clinicians and senior nurses.

Any specific issues of concern or emerging themes are discussed each month at the patient safety steering group. The patient safety team (working closely with other teams including patient experience, complaints and litigation, clinical risk, clinical audit) will then decide whether work needs to take place to improve these areas and the best way to take it forward.

The results of the review are included in monthly reports for the management board and the trust board. Data are also sent to the clinical outcomes group and the quality board led by the medical director.

Good performance is also recognised. When staff members are doing high-quality work, the assistant director of nursing will congratulate the specific staff member and alert the clinical lead.

Data from the reviews are forwarded to the strategic health authority each month.

Impact

The harm events review is an ongoing process. It has played a vital role in identifying quality and safety issues across the hospital.

Examples:

1. Vital signs monitoring was identified in the monthly review as an area that needed improvement. It was flagged to the patient safety steering group and ultimately passed to the improvement team to take up the work. A significant amount of work has now been done and quality has improved. Across the hospital cardiac arrests have decreased and rapid response calls have increased.
2. Over the past year the review process has helped the hospital identify peak period (winter) risk factors. As this year progresses toward the winter period the team is confident that the right work has been done to minimise the chances of the avoidable harm events recurring.

Learning

The global trigger tool has proven to be an effective way of systematically reviewing safety and quality across the hospital. Applying this method of review has enabled senior staff to gauge what has been happening at the hospital and focus action plans for the wards.

It is important to remember that the global trigger tool will produce a snapshot of performance. For reliability Royal United Bath NHS Trust also performs a mortality review every six months.