Global Trigger Tool
How to Guide

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Measure: Adverse Event Rate

The Global Trigger Tool is designed to provide a measure of harm experienced by patients in terms of adverse events. An adverse event is considered to be an unintended event that was caused at least partly by healthcare rather than the underlying disease and resulted in harm to the patient. The hospital adverse event rate is one of the key outcome measures for the 1000 Lives Campaign.

- The Campaign will use the hospital adverse event rate to track progress on preventing 50,000 episodes of harm. The actual measure being reported is the adverse event rate per 1,000 patient days.

- This measure will be produced by each NHS organisation using the Global Trigger Tool (GTT) on a sample of patient discharges on a monthly basis. Participating organisations have agreed to use the GTT on discharges from October 2007 onwards.

- The data gathered must be reported on the IHI Extranet. The seven months from October 2007 to April 2008 will be used to form a baseline position for Wales so it is important that data for all these months are submitted.

Please note the Campaign will only be reporting these measures on an all Wales basis.

This guide is designed as an adjunct to, not a substitute for Trigger Tool Training. It is strongly recommended that those undertaking case note reviews using the Trigger Tool have undergone training in their use. Further information on the use of the trigger tool is also available from the following documents which are all available on the 1000 Lives Campaign Extranet. www.ihi.org/extranetng

- UK Adverse Event Trigger Tool, Institute for Healthcare Improvement
- Innovations Series 2007 IHI Global Trigger Tool for Measuring Adverse Events
  (please note the trigger tool in this document is different from the one used by the campaign)
The Goal

Within the 2 year Campaign period, the aim is to prevent 50,000 episodes of harm and 1000 avoidable deaths.

Definition of Harm

In the IHI Global Trigger Tool, the definition used for harm is as follows:

“Unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment or hospitalization, or that results in death.”

Using the Trigger Tool

1 The Trigger Tool used by the 1000 Lives Campaign is UK Adverse Event Trigger Tool 2005 (see Appendix 1).

2 To undertake Trigger case note reviews a team of reviewers are required. The team must consist of at least 3 individuals trained in the use of Trigger Tools – the team should include a doctor and a nurse; other members of the team could be a pharmacist, risk manager or patient safety manager. To ensure consistency it is preferable that the team of reviewers remains relatively stable over time however it is also important to consider succession planning and consider recruiting and training a core of reviewers.

3 The team should randomly select and retrospectively review 20 case notes each month (or 10 every 2 weeks). In order to do this you need a system to:
   a) Identify and list discharged patients for each month. NB this includes deaths not just live discharges.
   b) Identify those patients with a length of stay greater than 24 hours but less than 30 days and over 18 years.
   c) Exclusions - Notes to be excluded from the trigger tool case note reviews:
      i) Obstetrics

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ii) Paediatrics

d) Be able to **randomly** select 20 case notes from this list. Preferably using a random number generator.
e) Review the notes once the patient is discharged and discharge summaries and coding has been completed.
f) Gather the notes required to a designated time & place.

4 Undertake the case note review using the tool as a template (Appendix 1) to search for triggers. The triggers are defined in Appendix 2. Use all notes and do not favour the thin sets. Set a 20 minute time limit, once this is reached stop and move on to the next set of records. The review should include:
   a. The discharge summary
   b. The medication/prescription chart
   c. Laboratory results for that admission
   d. The operative/theatre documentation
   e. Nursing and medical documentation
   f. If time permits any other areas of the case notes.

5 If there is more than one admission for an individual patient in a month, review the admission that was identified in the selection process.

6 Once a trigger is identified review the notes in more detail to identify if harm occurred. If harm has occurred, rate its severity. (Appendix 3 - Severity ratings)

7 Remember
   i) More than one trigger can contribute to one episode of harm
   ii) More than one trigger can contribute to several episodes of harm
   iii) Triggers may not lead to harm

8 Record all the information gathered on the trigger tool sheet. This includes triggers, any associated harm and the degree of harm.

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9 Enter all the data onto the Campaign Reporting Summary Spreadsheet. Complete the monthly tabs especially the number of adverse events and the length of stay for each patient as this will give you the adverse event rate. Completing the totals tab will give you a more detailed picture of what is happening over time.

10 Other issues may be identified and these can be recorded on a separate form (example available Appendix 4).

11 The object is not to find every possible adverse event in every set of case notes reviewed. The time limitation and the random selection of case notes intends for a reliable sampling of events and should be used to inform and evaluate the safety work in the health care organisation.

**Establish Feedback Mechanisms**

Organisations should examine the trigger tool data for lessons learned and patterns and trends. The information gained from this can also be used to identify areas of risk or sub-optimal care and provide opportunities to address system failures. In certain adverse events it may be appropriate to consider undertaking a serious case review or Route Cause Analysis to maximise the learning.

- Feedback information on the trigger tool data to:
  - Organisational boards as part of the ‘quality dashboard’
  - Front line clinical staff
- Look for lessons learned hospital-wide and link to critical incident reporting system.
- Use data to drive educational programs.
- Share the success stories.

**Track Measures Over Time**

Improvement takes place over time. Determining if improvement has really occurred and if it is a lasting effect requires observing patterns over time. Run

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charts are graphs of data over time and are one of the single most important tools in performance improvement. Using run charts has a variety of benefits:

- They help improvement teams formulate aims by depicting how well (or poorly) a process is performing.
- They help in determining when changes are truly improvements by displaying a pattern of data that you can observe as you make changes.
- They give direction as you work on improvement and information about the value of particular changes.

**Barriers That May Be Encountered**

- **Fear of change**
  All change is difficult. The antidote to fear is knowledge about the deficiencies of the present process and optimism about the potential benefits of a new process.

- **Communication breakdown**
  Organisations have not been successful when they failed to communicate with staff about the importance of the interventions, as well as when they failed to provide ongoing teaching as new staff become involved in the process.

- **Staff “partial buy-in” (i.e., “Is this just another flavour of the week?”)**
  In order to enlist support and engage staff, it is important to share baseline data and to share the results of improvement efforts. If the run charts suggest a large improvement compared to baseline, issues surrounding “buy-in” tend to fade.

You can learn more about the Model for Improvement on: www.1000livescampaign.wales.nhs.uk.

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## Appendix 1 Trigger Tool

### UK Global Trigger Tool

#### General care module

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Event Description and Severity E4</th>
</tr>
</thead>
<tbody>
<tr>
<td>G 1</td>
<td>Lack of early warning score or early warning score requiring response</td>
</tr>
<tr>
<td>G 2</td>
<td>Any patient fall</td>
</tr>
<tr>
<td>G 3</td>
<td>Dechiled</td>
</tr>
<tr>
<td>G 4</td>
<td>Readmission to hospital within 30 days</td>
</tr>
<tr>
<td>G 5</td>
<td>Shock or cardiac arrest</td>
</tr>
<tr>
<td>G 6</td>
<td>DVT/PE following admission evidenced by imaging or D dimmers</td>
</tr>
<tr>
<td>G 7</td>
<td>Complication of procedure or treatment</td>
</tr>
<tr>
<td>G 8</td>
<td>Transfer to higher level of care</td>
</tr>
</tbody>
</table>

#### Medication module

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Event Description and Severity E4</th>
</tr>
</thead>
<tbody>
<tr>
<td>M 1</td>
<td>Vitamin K</td>
</tr>
<tr>
<td>M 2</td>
<td>Naloxone</td>
</tr>
<tr>
<td>M 3</td>
<td>Flumazenil</td>
</tr>
<tr>
<td>M 4</td>
<td>Glucagon or 50% glucose</td>
</tr>
<tr>
<td>M 5</td>
<td>Abrupt medication stop</td>
</tr>
</tbody>
</table>

#### Lab test module

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Event Description and Severity E4</th>
</tr>
</thead>
<tbody>
<tr>
<td>L 1</td>
<td>High INR (&gt;5)</td>
</tr>
<tr>
<td>L 2</td>
<td>Transfusion</td>
</tr>
<tr>
<td>L 3</td>
<td>Abrupt drop in Hb or Hct (&gt;27%)</td>
</tr>
<tr>
<td>L 4</td>
<td>Biochemistry</td>
</tr>
<tr>
<td>L 5</td>
<td>Electrolyte abnormalities</td>
</tr>
<tr>
<td>L 6</td>
<td>Na+ &lt;126 or &gt;160</td>
</tr>
<tr>
<td>L 7</td>
<td>K+ &lt;2.5 or &gt;6.5</td>
</tr>
<tr>
<td>L 8</td>
<td>Hypoglycaemia</td>
</tr>
<tr>
<td>L 9</td>
<td>Raised Troponin (&gt;1.5 ng/ml)</td>
</tr>
</tbody>
</table>

#### Surgical care module

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Event Description and Severity E4</th>
</tr>
</thead>
<tbody>
<tr>
<td>S 1</td>
<td>Return to theatre</td>
</tr>
<tr>
<td>S 2</td>
<td>Change in planned procedure</td>
</tr>
<tr>
<td>S 3</td>
<td>Removed/Repaired repair of organ</td>
</tr>
</tbody>
</table>

#### Intensive care module

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Event Description and Severity E4</th>
</tr>
</thead>
<tbody>
<tr>
<td>I 1</td>
<td>Readmission to ICU or HDU</td>
</tr>
<tr>
<td>I 2</td>
<td>Unplanned transfer to ICU or HDU</td>
</tr>
</tbody>
</table>

#### Microbiology

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Event Description and Severity E4</th>
</tr>
</thead>
<tbody>
<tr>
<td>L 5</td>
<td>MRSA bacteremia</td>
</tr>
<tr>
<td>L 6</td>
<td>C. difficile</td>
</tr>
<tr>
<td>L 7</td>
<td>VRE</td>
</tr>
<tr>
<td>L 8</td>
<td>Housed infection</td>
</tr>
<tr>
<td>L 9</td>
<td>Non-housed pneumonia</td>
</tr>
<tr>
<td>L 10</td>
<td>Positive blood culture</td>
</tr>
</tbody>
</table>
Appendix 2 Trigger Definitions

(Adapted from the document - UK Adverse Event Trigger Tool, Institute for Healthcare Improvement)

GENERAL CARE MODULE

Early warning score
If an early warning scoring risk assessment system is in use, then the lack of an early warning score or an early warning score requiring a response may be a precursor to an adverse event.

Patient fall
A fall represents a failure of care. A fall that causes no harm may be the result of medications or failure to assess risk. Any fall that causes harm regardless of cause is an adverse event by definition. Review the physician progress notes, nursing or multidisciplinary notes for evidence of over sedation, lethargy or other conditions that may have contributed to a fall. Falls resulting in admission to the hospital need should be reviewed for causation and attributed as an adverse event if appropriate.

Decubiti (Pressure sores)
Decubitus ulcers are adverse events. Chronic decubiti are events if they occurred during a hospitalisation. If they occurred in the outpatient setting consider the aetiology (over sedation, etc.) to assess if an adverse event occurred.

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**Readmission within 30 days**
An adverse event may not manifest until after the patient has been discharged from the hospital, especially if the length of stay is minimal. As the chart is reviewed look to see if this admission was within a 30 days from a previous hospitalisation or did the current admission result in another future hospitalisation? Examples of adverse events may include surgical site infection, deep vein thrombosis or pulmonary embolism.

**Shock or cardiac arrest / crash calls**
All cardiac arrests need to be carefully reviewed as the end event of a flawed care process. Not all crash calls are adverse events. Cardiac or pulmonary arrest occurring intra-operatively or in the post anaesthesia care unit should always be considered as an adverse event. In the first 24 hours post-operatively, it is also very likely to be an adverse event. A sudden cardiac arrhythmia with a resulting crash call may well be associated with no adverse event, but failing to rescue a patient due to lack of recognition of physiologic change in signs and symptoms would be an adverse event.

**Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)**
Development of a DVT or PE during a hospital stay should be considered as an adverse event. Even if all appropriate preventive measures appear to have been taken, from a patient’s perspective this is a harmful event. If the hospitalisation occurs due to a DVT or emboli look to see if it is a medication related event or if there was a recent healthcare event.
Complication of Procedure or Treatment
Evaluate the reason for the procedure. The procedure itself may be required due to an adverse event. Look for complications from any procedures. Procedure notes do not always note the complications especially if the complication occurs hours or days after the procedure note has been documented.

Transfer to higher level of care
Transfers include either within hospital, to another hospital, or to your hospital from another. Transfer to an intensive care unit or high dependency unit is a trigger that an adverse event may have occurred. Admission to intensive care or HDU may have occurred when a patient’s clinical condition deteriorated perhaps secondary to an adverse event. When reviewing this trigger, look for the reasons for the transfer and the change in condition. For example, in the case of admission to intensive care following respiratory arrest and intubation, if the respiratory arrest was a natural progression of an exacerbation of chronic obstructive pulmonary disease (COPD), it would not be an adverse event, but if it was caused by a pulmonary embolism that developed post-operatively, or over-sedation of a patient with COPD it would be an adverse event.

SURGICAL CARE MODULE
Return to theatre
A return to surgery is a trigger to check whether an adverse event occurred during the previous surgery.
An example of an adverse event is a patient who had internal bleeding following the first surgery and required a second surgery to stop the bleeding. Patients who have a second surgery that is exploratory, but does not reveal anything (looking for bleeding, or a suspected retained surgical instrument) would be considered as an adverse event.

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Sometimes a return to theatre after a previous surgical procedure is planned and is therefore not an adverse event. For example a procedure that must be completed in stages or a procedure that is completely unrelated to the first procedure and the result of another diagnosis, such as pacemaker insertion after a bowel resection. It is important to distinguish whether the additional procedure was planned.

Change in planned procedure
An unexpected change in surgical procedure can be the result of unexpected findings after the procedure has started, a change in clinical condition during the procedure or due to an adverse event occurring during the procedure. When the procedure on the post-operative note is different from the procedure planned in the pre-operative note or documented in the surgical consent, a reviewer should look for details as to why the change occurred.
An unexpected change in procedure due to equipment failure or missing equipment is an adverse event if the patient experienced additional pain, time in the hospital, is x-rayed immediately post operatively or other harm as a result of the different procedure.

Removal / Injury or repair of organ
Review theatre notes and postoperative notes for evidence that the procedure included repair, injury or removal of any organ. Except in cases of trauma, where organ injury or suspicion thereof is the reason for surgery, this may indicate an operative event damaging the organ.
INTENSIVE CARE MODULE

Readmission to Intensive Care or High Dependency Care

Any readmission to the ICU has a high probability of an event occurring. Look for a relationship to a precipitating adverse event. Examples might be pulmonary oedema secondary to excess fluid administration or an aspiration.

Unplanned transfer to intensive care or high dependency care

Transfer to an intensive care unit or cardiac care unit is a trigger that an adverse event may have occurred. The admission to intensive or critical care may have occurred when a patient’s clinical condition deteriorated perhaps secondary to an adverse event. When reviewing this trigger, look for the reasons for the transfer and the change in condition. For example, in the case of admission to intensive care following respiratory arrest and intubation, if the respiratory arrest was a natural progression of an exacerbation of chronic obstructive pulmonary disease (COPD), it would not be an adverse event, but if it was caused by a pulmonary embolism that developed post-operatively, or over-sedation of a patient with COPD it would be an adverse event.

MEDICATION MODULE

Vitamin K

If Vitamin K was used as a response to a prolonged INR, review the chart for evidence of bleeding. The laboratory reports should indicate a drop in haematocrit or guiac-positive stools. Check the progress notes for evidence of excessive bruising gastrointestinal (GI) bleed, hemorrhagic stroke, large haematomas or other bleeding episodes.
Naloxone
Naloxone (Narcan, Nalone, Narcanti) is a powerful opiate (narcotic) antagonist. If it has been used, over dosage of opiates (narcotics) is a frequent finding.

Flumazil
Flumazil (flumazepil, Anexate, Mazicon, Romazicon) is used to reverse the effects of benzodiazepime sedation. If administered look for the reason for this and asses if harm occurred. Over sedation in an elderly patient requiring administration of Flumazil would be an adverse event.

Glucagon or 50% glucose/dextrose
The administration of glucagons or 50% glucose/dextrose suggests the patient may have experienced an adverse event related to hypoglycaemia. The chart should be reviewed for associated use of insulin or oral hypoglycaemics with evidence of symptoms which are commonly associated with hypoglycaemia followed by administration of glucose/dextrose or glucagon (oral or intravenous).

Abrupt medication stop
In the doctors orders, whenever "hold" or "stop" all medication orders appear, look for the reason this was done. Frequently it indicates an adverse event of some kind.
LAB TEST MODULE
Haematology
High INR (>5)
Look for evidence of bleeding to determine if an adverse event has occurred. An elevated INR in itself is not an adverse event.

Transfusion
Procedures can require intra-operative transfusion of blood products for replacement of estimated blood lost, but this has become less common with ‘bloodless surgery’. Any transfusion of packed red blood cells (RBC’s) or whole blood should be investigated for causation including excessive bleeding, unintentional trauma of a blood vessel, etc. Transfusion of many units within the first 24 hours of surgery, including intra-operatively and post-operatively, will commonly be related to a peri-operative adverse event. Exceptions would be where excessive blood loss occurred pre-operatively. Fresh frozen plasma and platelets can reflect system problems that include failure to plan changes in anticoagulants prior to surgery and the necessity to reverse quickly in order to do the surgery.

Abrupt drop in Hb or Hct (>25%)
Any drop of 25% or greater in Hg grams or Hematocrit (Hct) requires an explanation. All bleeding associated events might commonly see this as a trigger. Smaller “drops” obviously can also be associated with adverse events, but the question as to whether harm occurred needs to be subjectively answered. Anticoagulant use is frequently observed to be associated with this particular trigger.

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Biochemistry

Rising urea or creatinine (>2x baseline)
Review laboratory records for rising levels of either serum urea or creatinine. If a change of two times greater than the patients baseline levels is found, review medication administration records for medications known to cause renal toxicity. Review doctors progress notes, the medical history and examination for other causes of renal failure, such as pre-existing renal disease or diabetes that could have put the patient at greater risk for renal failure. Subjective judgment may be needed to determine whether renal failure was event induced if multiple factors are identified.

Electrolyte abnormalities (Na+ <120 or >160 K+ <2.5 or >6.5)
Electrolyte imbalance can either precede or be associated with adverse events. Not all patients with electrolyte abnormalities will be symptomatic. Review the case notes for evidence of symptoms.

Hypoglycaemia (<3mmol/l)
Not all patients will be symptomatic; if the patient is not symptomatic there is probably no adverse event. Review for associated use of insulin or oral hypoglycemics with evidence of symptoms and commonly followed by and administration of glucose (oral or intravenous). Often the signs and symptoms description will be noted by nursing where lethargy, shakiness, etc. will be described.

Raised Troponin (>1.5 ng/ml)
A post-operative increase in troponin levels may indicate a cardiac event. Reviewers will need to use clinical judgement as to whether a cardiac event has occurred.

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MICROBIOLOGY
A Health Care Associated Infection (HCAI) is defined as a localised systemic condition that results from an adverse reaction to the presence of an infecting agent or its toxins that was not present or incubating at the time of admission (infections developing >48hrs after admission are usually included). Any infection starting in hospital needs to be considered as HCAI unless clearly originating from outside the hospital. Any infection occurring in hospital is an adverse event. Exceptions might be the urinary tract infection from outside the hospital, or infection being treated but not contracted in hospital.

MRSA bacteraemia
MRSA bacteraemia is a blood stream infection caused by Methicillin Resistant Staphylococcus Aureus (MRSA). Review the microbiology reports for any positive MRSA bacteraemia.

Clostridium Difficile (C. difficile)
If a patient is on or has been on multiple antibiotics this adverse event may be observed. Review the microbiology reports for any positive C. difficile toxin positive results, this is an adverse event.

Vancomycin Resistant Enterococcus (VRE)
Review the microbiology reports for any VRE. If VRE is identified in a patient review the records for any HCAI.

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**Wound infection**

Review records (including clinical notes) for a wound infection including central line insertion site, surgical site or other wound infection. Any infection occurring in hospital is an adverse event. Exceptions might be a wound infection being treated but not contracted in hospital. Note a positive microbiology report is not an accurate diagnosis of a wound infection there needs to be clinical confirmation.

**Nosocomial (Health Care Associated) Pneumonia**

Any pneumonia diagnosed in the ICU needs to be looked at carefully. Nosocomial pneumonia should be considered where pneumonia is diagnosed after 48hrs of hospital admission. Readmissions could also represent pneumonia from a previous hospitalisation, particularly if antibiotic resistant.

**Positive blood culture**

A positive blood culture at any time during hospitalisation must be investigated as an indicator of an adverse event. Contamination of blood cultures occurs at around 10% therefore a positive blood culture by a contaminant is not an adverse event. A positive blood culture of clinical significance should be regarded as an adverse event.
Appendix 3 Severity Ratings

The IHI Global Trigger Tool adapts the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Index for Categorizing Errors.

NCC MERP brings together leading health care organizations to meet, collaborate, and cooperate to address the interdisciplinary causes of errors and to promote the safe use of medications.

Although originally developed for categorizing medication errors, these definitions can be easily applied to any type of error or adverse event.

The IHI Global Trigger Tool counts only adverse events: harm to the patient (as defined above), whether or not the result of an error.

**Category E:** Temporary harm to the patient and required intervention
**Category F:** Temporary harm to the patient and required initial or prolonged hospitalization
**Category G:** Permanent patient harm
**Category H:** Intervention required to sustain life
**Category I:** Patient death
## Appendix 4

### 1000 Lives Campaign- Trigger Tool Template for Recording Issues /Actions

<table>
<thead>
<tr>
<th>Review no</th>
<th>Pt Hospital/Record No</th>
<th>Age</th>
<th>Date of Admission</th>
<th>Date of Discharge</th>
<th>Date of Death (where Applicable)</th>
<th>LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reason for Current Admission:**

**Discharge Summary –Code**

**Additional Issues**

**Reviewers notes**

### Additional Information

- **# Triggers**
  - Trigger codes
  - Required Actions:

- **# Events**
  - Level of Harm (E-I)
  - *REMEMBER TO COMPLETE THE TRIGGER TOOL EXCEL SPREADSHEET REPORTING TEMPLATE EVERY MONTH & REPORT YOUR ADVERSE EVENT RATE*

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The 1000 Lives Campaign is being run as a collaborative, involving the National Leadership and Innovation Agency for Healthcare, National Patient Safety Agency, National Public Health Service, Wales Centre for Health and the Welsh Assembly Government's Clinical Governance Support and Development Unit.