

Ward-Patient eQMS with Error Recovery Protocols Saves many Thousands of Lives Globally.

Overview: Human error (HE) in global medicine kills 2.6 million annually placing patient safety on the G20 Summit (1). Solutions available (a) more staff training dominated by a HE-rate of about one error in 200 tasks and (b) a simple computer system used by high reliability organisations such as Banking with zero HE.

With 70% of adverse events occurring on wards, patients should electronically acknowledge each intervention with their wristband-data. Missed interventions now detectable are compellingly alarmed reducing the consequences of HE 10,000 fold.

Problem: The Healthcare sector have no “HE Recovery Protocols”
on their wards (2a).

This massive management error is punishable with fines and imprisonment across every other sector including Nuclear Rail Shipping etc. by the CPS here in the U.K.

HE recovery protocol for ward-patient safety: The patient is placed in a computerised quality-loop enabling them to acknowledge received MDT interventions by tagging their personal wristband-data back to the computer care plan. Missed interventions easily detected by the software-checklist now compellingly alarmed on-screen in front of health worker **and** patient. Nigh impossible to ignore, missed interventions are corrected, reducing the consequences of HE by more than a factor of ten thousand (10^4) (2b).

Example: Opioid overdose prevention: Software analyses patient's analgesic ladder. Their previously tagged opioid consumption displayed with opioid headroom warning. The patient tags acknowledging and updating the new opioid volume correctly administered. The system would have saved 450 Gosport patients 30-years ago, and currently under live investigation by Police (Operation Magenta).

Conclusion: Placing the ward patient in a computer driven tagged quality loop significantly reduces HE-consequences improving compliance lowering death rates adverse events bed-days and litigation. The tag system has a long-standing pedigree too. U.K. Bank customers have electronically tagged 30 million times a day, keeping accounts **healthy and error free** for decades.

Please could colleagues on our hub help the NHS/CQC understand this established Industrial H&S concept with a view to trialling it.

References:

[1] [The cost of patient safety inaction: Why doing more of the ...](#) A .M. Alhawsawi. Patient Safety Hub 2020.

[2a] The Blame Machine. R B Whittingham. ISBN 0-7506-5510-0. **Industrial H&S**. <https://books.google.co.uk/> then type “5.3 error recovery ” (page 74-75).

[2b] <https://books.google.co.uk/> then type “1. compelling feedback ” (page 78-79). Compelling feedback reduces HE by a factor of 10,000.

Foot note: Sometimes whole industries become unwilling to look too closely at system faults and the blame machine swings into action. Pity the individual health worker not protected by management HE recovery protocols. <https://books.google.co.uk/> type “The blame machine preface xii” last two paragraphs and xiii.

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