Ward-Patient Safety Solution:

An eQMS with Alarmed Error Recovery Protocols.

Abstract: Human error (HE) in global medicine kills 2.6 million annually placing patient safety on the G20 Summit (1). Solution: (a) more staff training with mindfulness and candour all dominated by a HE rate of about one error in 200 tasks or (b) a simple **computer system** used by the high reliability Banking sector with zero HE.

Ward-patients should electronically acknowledge each intervention with their wristband-data. Missed and incorrect interventions are made **detectable and compellingly alarmed** reducing HE consequences **10,000** fold (2a).

Problem: The global Healthcare sector has no "**Error Recovery Protocols (2b)**"on wards. This massive management error is punishable with fines and imprisonment across all sectors here in the U.K. by the Crown Prosecution Service (CPS). So, beware managers sacking whistle blowers.

Error 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 or incorrect interventions of barcoded medicine volume and route etc. easily detected by the software-checklist and compellingly alarmed on-screen in front of healthcare worker **and** patient. Impossible to ignore, errors are corrected and reduced ten thousand fold.

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 and CPS (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 litigation and WB. 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. This digital patient safety system fits seamlessly with the PSL blueprint for action (3,4).

References:

[1] The cost of patient safety inaction: Why doing more of the … A .M. Alhawsawi. Patient Safety Learning 2020.

[2a] The Blame Machine. R B Whittingham. ISBN 0-7506-5510-0. Industrial H&S. https://books.google.co.uk/ then type "1. compelling feedback " (page 78-79). Compelling feedback reduces HE by a factor of 10,000+.

[2b] https://books.google.co.uk/ then type "5.3 error recovery " (page 74-75).

[3] https://www.youtube.com/watch?v=S-5lmOOWzbk Helen Hughes CE. Patient Safety Learning. Aug 2019.

[4] https://www.pslhub.org/learn/patient-safety-learning/patient-safety-learning-documents/blueprint-for-action/patient-safety-learning-a-blueprint-for-action-2019-r142/

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Comments by Steve Turner: Thanks Derek, I think you have hit on a critical issue and solution. As a community nurse, someone who is keen on interdisciplinary working & patient empowerment I'd like to see ways in which this approach can be adapted and adopted to work outside hospitals. I'm sure it can be. Time for the #NHS to truly modernise and focus on patients safety, and patient involvement, in IT projects.

This (eQMS) looks good. I hope the #NHS I.T. will catch up with this. It shows that health is not "unique" when it comes to safety and human error. I particularlylike the way the patient is an equal part of this solution. I agree...
"The system would have saved 450 Gosport patients 30-years ago, and currently under live investigation by Police (Operation Magenta)." Thank you.

Industrial H&S.

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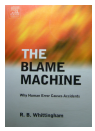

R. B. Whittingham.