Ward-Patient Safety Solution.
(An eQMS with Alarmed Error Recovery.)

Overview: Human error (HE) in global medicine kills 2.6 million annually (<u>Covid to date</u>) placing patient safety on the G20 Summit (1). **Solutions:** (a) staff training with mindfulness and human-factors awareness dominated by a human error-rate of about one error in 200 tasks or (b) an electronic quality management system (eQMS) used by high reliability sectors such as Banking with **zero HE**.

Ward-patients should electronically acknowledge on-screen each intervention with their wristband-identity. Additionally, missed and incorrect intervention **errors made detectable and alarmed** against the patient's care plan checklist. Together, this formidable classic industrial H&S technique, reduces HE consequences **10,000-**fold (2a) protecting patient, healthcare worker and management.

Problem: The global Healthcare sector have no "**error recovery protocol (2b)**"on wards. This massive management error in any sector punishable by the Crown Prosecution Service (CPS) here in the U.K. for the accidental death of a worker, customer or general public.

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 incorrectly attempted interventions of barcoded medicine, volume route life-sign debriefs etc. easily detected against their software-checklist and **compellingly alarmed** on-screen in front of healthcare worker **and** patient in every department. Impossible to ignore errors, HE consequences 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 the consequences of HE improving compliance death-rates adverse-events bed-days litigation whistle blowing and never-events. The tag system has a long-standing pedigree too. UK Bank customers have electronically tagged 30 million times a day keeping accounts **healthy and error free** for decades.

References:

[1] . https://www.pslhub.org/blogs/entry/521-the-cost-of-patient-safety-inaction-why-doing-more-of-the-same-is-unsustainable/ Helen Hughes (CE) PSL.

[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 consequences by a factor of 10,000+.

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

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14.1.2021.

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 particularly like 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.

Patient Safety Learning

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