Digital Clinical Communication – How does it affect patient safety?

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The Wrong Insulin Dose

“I’d text I think two of the nurses and I didn’t get a response, so I tried ringing again. And then no one picked up [...] I just altered my insulin dose myself to how I thought it would be. Which actually turned out to be wrong, so it did leave an impact because obviously it took a good week to sort itself out.” (Young patient, Diabetes clinic)
“And certainly we’ve had cases with service users who emailed information suggesting an increasing risk to themselves out of hours and no one’s responded immediately, but they have been using it as a form of communicating, you know, risk. So I think... and that causes sort of difficulty within the management of that case.”
(Healthcare professional, Mental Health clinic)
Risk Categories

- Inadvertent disclosure of sensitive information
- Communication failures
- Failure to record email and text communication
- Failure to consult patient’s notes before emailing / texting
How do people deal with the risks?

- Common sense
- Happy ignorance
- Restrict the use of email and text
Safety Management Process

• Keeping patients safe, and maximising the benefits of technology requires a proactive approach

• Variability in use: local risk assessment

• Digital forms of communication are still “under the radar”

• Little education and training to raise risk awareness
Collaborating Organisations:
University of Warwick, King’s College London, University of Oxford, University Hospitals Coventry and Warwickshire NHS Trust, King’s College London NHS Trust, Guy’s and St Thomas’ NHS Trust

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