

Technology

Technology is now a central component in everyday living, and it is also developing quickly in health care. We should consider how we can use technology to help us with the challenges we face when trying to maintain patient safety.

It makes sense for us to use all available resources to understand and manage self-harm better. An individualised approach must be the priority because patients' needs and motivations differ.

Digital technology gives us new opportunities to provide inpatient services differently. With strong clinical leadership to embed a positive culture to support the use of technology, this can complement the therapeutic relationship, the most important element of patient safety.

Use of technology must be subject to checks on safety, accuracy, effectiveness and suitability. Other important considerations are the absence of much research on the benefits of technology and concerns about how using it can affect patients' privacy and dignity. Use of vision based technology should take into account a patient's need for privacy, and used only with the patient's consent or in their best interests as agreed as part of a recognised process.

Services must take care not to rely on technology as an alternative to direct staff involvement with patients. For example, personal involvement might identify risks or signs of distress that technology cannot. Any concerns could then be dealt with before the patient reaches a crisis.

Ward-based clinical staff may benefit from training on new products. This could be via a service level agreement by product providers or internal sessions. This would be in addition to regular ligature training.

There is more information about [Technology in care](#) on CQC's website.

Key considerations

Have all the steps in the guiding principles for procurement been followed?

Is there a shared understanding of the purpose of the technology – why are we considering the use of technological resources?

- Have we fully considered its impact on safety vs privacy and dignity for patients and is it being used with their consent? (see Therapeutic environment in the built environment chapter)
- How have we communicated the purpose to those who will operate/utilise the resource/equipment in the context of ligature risk?
- Have we fully considered and communicated to all staff the limitations/constraints of the technology concerning minimising ligature risk?
- Are there any implications relating to consent, confidentiality and/capacity?
- Does the resource/equipment require a maintenance program/review to monitor that it is fit for purpose in context of ligature risk?
- Is a contingency plan required should the resource/equipment fail to operate for managing ligature risk?
- Where relevant, how have we communicated the use of resource/equipment with patients and carers to ensure a shared understanding of purpose and use in practice?

- How does the resource/equipment impact on patient experience in creating a home-like environment?

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