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ISQUA15-1242

AREAS FOR IMPROVEMENT RECOMMENDED BY HOSPITAL ACCREDITATION PROCESS IN JAPAN

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Objectives: To provide high quality in health care, it is important for hospitals to identify the points for improvement objectively. Japan Council for Quality Health Care (JCQHC) is a third-party organization conducting hospital accreditation in Japan based on their accreditation scheme. It evaluates based on around 90 items in 4 areas (Area 1: Promotion of patient-centered healthcare, Area 2: Quality medical practice - care process, Area 3: quality medical practice: Implementation of functions for providing safe care in each section, Area 4: organization management for achievement of ideas). The purpose of this study is to review areas for improvement recommended by hospital accreditation process in Japan.

Methods: The 441 hospitals which had an accreditation survey of JCQHC in FY 2013 were selected and a distribution of the result (S, A, B, and C) of each item was calculated in each 5 accreditation type (Hospital type 1, Hospital type 2, Rehabilitation hospital, Long-term care hospital, and Psychiatric hospital). Each 3 item which had the largest number of hospitals getting rate C, meaning Not Met, were selected in 5 accreditation types, and the trend of their contents were analyzed.

Results: In each area, the total number of hospitals which got C was as follows: Area 1 was 19, Area 2 was 138, Area 3 was 65 and Area 4 was 40.

The top 3 items which had the largest number of hospitals which got C was shown in the table below.

Rank	Hospital type 1 (N=126)	Hospital type 2 (N=226)	Rehabilitation (N=20)	Long-term care (N=40)	Psychiatric (N=49)
	Item (%)	Item (%)	Item (%)	Item (%)	Item (%)
1	4.2.3 (7.3%)	2.1.5 (7.1%)	2.1.4 (10.0%)	2.1.5 (15.0%)	3.1.1 (17.2%)
2	2.1.5 (7.1%)	4.2.3 (6.6%)	2.1.5 (10.0%)	2.1.9 (12.5%)	2.1.4 (10.3%)
3	2.2.20 (5.0%)	3.1.1 (4.4%)	3.2.1 (7.7%*)	3.1.8 (10.0%)	2.2.14 (4.0%)

* As the number of N was very small, it is a reference value.

2.1.4 Preventive measures against communication errors are implemented

2.1.5 Measures are taken for the safe use of medications

2.1.9 Activities are conducted for control of healthcare-related infections

2.2.14 Drug administration/injection is given reliably and safely
2.2.20 Physical restrictions are applied properly for safety assurance
3.1.1 Drug control function is fulfilled properly
3.1.8 The function of cleaning and disinfection is properly fulfilled
3.2.1 The function of pathological diagnosis is properly fulfilled
4.2.3 Safety and health administration of the hospital staff is properly conducted

To summarize the contents of the 15 items above, the items related to safety management including infection control were account for 14 items (90 %), which were except 3.2.1. 7 out of 15 (47%) were categorized as medication-related. 2 of them (13%) were about staffs' safety, communication error, and infection control. 1 of them were categorized as physical restraint, and pathology respectively.

Conclusion: In conclusion, by reviewing quantitatively, the hospital accreditation process in Japan issued recommendations for improvement most frequently in the areas of safety management, including medication management, infection control, prevention of communication errors, and staff safety. Based on the facts that hospitals were accredited only after realizing improvement in these areas, it was evident that hospital accreditation contributed to improving safety management in health care.

References:

1) Hospital Accreditation Standards <JCQHC 3rdG:Ver1.0>

ISQUA15-1122

WHAT DO GENERAL PUBLIC WANT TO KNOW BEFORE VISITING MEDICAL INSTITUTES?

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Objectives: It is an accountability for medical institutes and health care providers to evaluate and publish their quality on a daily basis. In addition, it is expected to improve and to level the quality in health care. However, the publication of the results has some challenges, for example general public would not understand the meaning of the data well and have the wrong images based on misunderstandings.

The goal of this study is to know what general public want to know before visiting medical institutes and to know their understanding of the quality in health care.

Methods: We implemented a questionnaire via internet from January 2014. The questions were listed below:

1. If you have disease, how do you find a hospital to visit?
2. Which points are important for you to select a hospital to visit?
3. Do you know the word “Quality Indicator (QI)”?
4. If hospitals publish their data on their web site, are they useful for you to select a hospital?
5. How do you feel that a hospital publish their QI data by themselves?
6. How do you feel about a web site comparing QI data among some hospitals?
7. Do you know JCQHC?
8. Have you or your family ever been in a hospital before?
9. Are you a health care professional? / Have you worked in a medical institute?
10. What kind of information do you want to know before visiting medical institutes? (optional free-answer question)

The participants were registered to MACROMILL, INC. in advance. The participants were divided into 10 groups by sex and age, and the 309 applicants of each group were accepted on the first-come-first served basis (N=3090).

Results: In Q9, 6.0% respondents answered “yes”. We called this group as “health care providers”.

In Q2, over 70% respondents considered the items below as “very important” or “important”:

- The institute has suitable and specific departments (93.7%);
- The institute is located near to their home/workplace/school (86.5%);
- The institute has high specialties (75.7%);
- And Good attitude of staffs (72.2%).

Additionally, the point of "good attitude of staffs" was significantly different between men and women by chi-square analysis (63.3% and 81.1% respectively; p<.01).
As for Q3, the number of "I do not know the word." was 84.7% in total and 68.3% in the health care providers. This result shows that to evaluate health care quality with QI, or maybe the concept of QI, has not been popular yet, even in the health care providers.
In Q5, "I want to see the QI data related to my diseases" and "every hospital should publish its QI data" were selected by 51.0%, 40.6%, respectively. The answer of "if QI data is better, hospitals should be given more economic incentives." was selected by only 12.2% in total, but it was significantly different in men and women (14.7% vs 9.6%; p<.01).
In Q6, the answers were different by the age of respondents. For example, "I have ever seen / I refer a web site comparing QI data.", and "every hospital should publish its QI data" were selected by 21.5%, 22.2% of 20s vs 12.8%, 40.8% of over 60s, respectively (p<.01; chi-square).
In Q10, the answers categorized in "reputation and patients' satisfaction", "doctors' skills and specialties", "waiting time / congestion situation" and "price / how to pay" were prominent. Also the more basic answers such as "I do not know which specialist I need to be seen" and "there are female physicians or not" were distinct.

Conclusion: General public were highly interested in the health care quality and QI data. Senior male group most expected that hospitals should publish their QI data. There were various needs for information depending on age and sex of the respondents.

ISQUA15-1286

APPLICATION OF KNOWLEDGE GAINED THROUGH ADVERSE EVENT REPORTING SYSTEM AND NO-FAULT COMPENSATION/PEER-REVIEW SYSTEM TO NEW PEER-REVIEW SYSTEM ON CLINICAL DEATH CASE IN JAPAN

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Objectives: Japan Council for Quality Health Care (JCQHC) has carried nationwide adverse event reporting system and no-fault compensation/peer-review system for cerebral palsy. In those programs, adverse event was investigated, analyzed and eventually gave rise to a peer-review report though the degree of detail varies. The Japanese government is planning to build a new peer-review system on patient death on October 1, 2015. The idea of how to introduce the knowledge achieved by those two projects to the new peer-review system will be presented.

Methods: The adverse event reporting system has been operated through web-based system covering broad medical specialties, while the compensation/peer review for cerebral palsy has been based on case-by-case, in other words, in depth review in restricted realm of medicine. The optimum combination of those two different methods was reviewed seeking full coverage of clinical death case in a new peer-review system.

Results: The reporting system collected 3,194 accident and 29,736 incident reports in 2014 under the condition of anonymity from 1,399 medical institutions accounting for 16% of Japanese hospitals. JCQHC published annual/quarterly reports and monthly alerts as planned in 2014 for recurrence prevention. It should be stressed that web-based reporting and analyzing system developed in JCQHC has enabled to efficiently deal with a great number of cases reported from entire medical specialties. In contrast, the Japan obstetric compensation/peer review system has an intensive peer review in which expert groups review and eventually compile a peer-review report of individual cases. Six hundred and fourteen reports have been completed and delivered to both families and childbirth facilities so far. Despite the initial criticism that intensive causal analysis and in-depth reports may ignite conflict between childbirth facilities and families, no significant rise in the number of liability insurance payment/ lawsuit case for cerebral palsy has been observed. This peer-review system is characterized as the one which applies in-depth review to restricted realm of medicine in contrast to the one developed in the adverse event reporting system as we expect that only 400-500 cases are dealt annually in Japan. As both systems grow steadily, the government is planning to build a new peer-review system specific to clinical death aiming at patient safety promotion based on revised "Health service law". 1300-2000 death cases are expected to be subjected to the new system. As worry on too much burden of peer-review work on medical institutions and allegedly possible conflict ignited by compilation of in-depth peer-review report still lingers, volatile discussions on various points composing of opinions such sides as doctor, lawyer and civil representative is now underway. It

appears that clinical death cases should be processed in the two different manners according to description of each case making full use of knowledge achieved by JCQHC's adverse event reporting system and no-fault compensation/peer-review system.

Conclusion: The new peer-review system will begin on Oct 1. JCQHC's adverse event reporting system and no-fault compensation/peer-review system has fostered two different methodologies to cover entire adverse event for prevention. They surely provides with ideas which enable the new system to be operated efficiently and effectively.

References:

1) The website of the Japanese medical adverse event reporting system (ENGLISH): http://www.medsafe. jp/contents/english/index.html

ISQUA15-1482

PRACTICAL APPROACHES AND DEMANDS FOR PROMOTING THE UTILIZATION OF CLINICAL PRACTICE GUIDELINES IN JAPAN

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Objectives: MINDS (Medical Information Network Distribution Service) is a consignment project for MHLW (Ministry of Health, Labor and Welfare) managed by Japan Council for Quality Health Care (JCQHC). MINDS has the mission to disseminate and implement evidence-based clinical practice guidelines (CPG) and related information not only for medical practitioners but also patients and public. CPG need to help decision-making between patients and medical practitioners, however it is not clear whether guideline help the shared decision-making sufficiently. The purpose of this study is to describe MINDS project for CPG-based information tool targeted patients and public and clarify the agenda in this project.

Methods: We evaluated and selected CPG by two-stage screening and systematic evaluation process for posting CPG on MINDS website. After these process, we provided three types of CPG-based commentary; Guidelines Commentary developed by guideline development group (GDG), CPG-term commentary, and Basic explanation of diseases, for the CPG identified by the procedure. Guidelines Commentary could be posted after obtaining author’s permission. For CPG-term commentary, we extracted technical terms in CPG, and made plain explanation for each terms. For Basic explanation of diseases, we proposed basic summary about diseases with charts and illustrations.

Results: After screening and systematic evaluation process, 91 CPG were posted on MINDS website from April 2011 to January 2014. A total of 41 CPG-based information tool targeted patients and public were posted. 21 (51.2%) Guidelines commentary, 13 (31.7%) Basic explanation of diseases, 7 (17.0%) CPG-term commentary were published. The most common disease category was cancer (26.8%), and the organ of digestion (17.0%), and orthopedics (17.0%).

Conclusion: The number of posted CPG on MINDS website is increasing rapidly, however, those of CPG-based commentary is not sufficient. It is necessary to review the development process of CPG-based commentary. MINDS is preparing to hold questionnaire for patients and public to improvement CPG-based commentary.

ISQUA15-1315

IMPACT OF PEER-REVIEW REPORT IN TERMS OF QUALITY IMPROVEMENT AND CURB OF LAWSUIT/DAMAGE CLAIM IN NO-FAULT BASED COMPENSATION / PEER-REVIEW SYSTEM FOR CEREBRAL PALSY IN JAPAN

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Objectives: The Japan obstetric compensation system for cerebral palsy was launched by Japan Council for Quality Health Care (JCQHC) in 2009 in response to the shortage of obstetrician due to surging conflict over profound cerebral palsy cases. The system has underwent first major appraisal and overhaul in 2014. Through the appraisal process, peer-review report compiled in the system was reviewed in terms of quality improvement and curb of lawsuit/damage claim to verify if the system has been effectively operated in consistent with the aim of it.

Methods: The compensation system for cerebral palsy has published peer-review reports which was eventually delivered not only to childbirth facilities but to guardians with children suffering cerebral palsy. Statistics of lawsuit case/damage claim was reviewed and satisfaction survey on the report was conducted to both childbirth facilities and guardians.

Results: The Japan obstetric compensation system provides eligible case with monetary compensation and peer-review report. Review committee to discuss eligibility of filed case only confirms birth weight, gestational week and congenital or post-neonatal factor causing cerebral palsy. It is of note that liability of obstetric care is out of scope in a review committee characterizing the process as “No-fault basis”. No-fault based compensation is beneficial in providing with prompt compensation in comparison with lawsuit case which normally takes relatively long period of time to reach resolution. Expert groups have been intensively working to compile peer-review reports. Six hundred and fourteen reports have been completed and delivered to both families and childbirth facilities so far. A survey on the report showed that it was mostly favored by both childbirth facilities and families. Majority of answer was that they were satisfied with the report because it was crafted by neutral third body which is JCQHC. The result reminded us again that those who underwent harmful healthcare in medicine have said to be keen to know about “The truth in the case”, i.e. “What happened and why it happened in the adverse event?”. Despite the initial criticism which arouse at the launch of the system that compilation of in-depth peer-review report may ignite conflict between childbirth facilities and families leading to reversed effect in light of the aim of the system, no significant rise in the number of damage claim for cerebral palsy has been observed. In contrast, it has been seen that the decline of lawsuit cases in obstetric specialty is sharper than that of entire medical specialties. The system also published a written material in 2014 carrying four important themes to improve quality of obstetric care such as care for uterine rupture, care for intrauterine infection and so on. The report is circulated among obstetricians or midwives on occasions such as annual meeting of scientific societies. With the

satisfactory achievements and improved perinatal care on the background, the expansion of the system was approved in the government committee. Therefore, it is expected that the system will be more influential in the improvement of obstetric care in Japan.

Conclusion: The Japan obstetric compensation system for cerebral palsy may have been effective in easing conflict on cerebral palsy cases and improving quality of obstetric care.

References:

1. The website of the Japanese Obstetric Compensation System for Cerebral Palsy (Available only in Japanese) http://www.sanka-hp.jcqhc.or.jp/
2. Guide to The Japan Obstetric Compensation System for Cerebral Palsy (English leaflet) http://www.sankahp.jcqhc.or.jp/documents/other/pdf/bira_english_color201407.pdf

ISQUA15-1381

PREVENTING MEDICATION ERRORS BASED ON NATIONWIDE PHARMACEUTICAL NEAR-MISS EVENT REPORTING SYSTEM AND MEDICAL NEAR-MISS/ADVERSE EVENT REPORTING SYSTEM IN JAPAN

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Objectives: Medication errors are one of the most common incidents occurring in health care system. The nationwide pharmaceutical near-miss event reporting system funded by the government was launched by Japan Council for Quality Health Care (JCQHC), a neutral third body, in 2009. JCQHC also operates nationwide medical near-miss/adverse event reporting system to improve patient safety through sharing information. The objectives of this study are to review the achievement of these projects concerned cooperation between hospital/clinic and community pharmacy to prevent medication errors.

Methods: JCQHC have collected pharmaceutical near-miss events reported from community pharmacies voluntary participating the project, medical adverse events reported from mandatory/voluntary participating medical institutions and medical near-miss events reported from voluntary participating medical institutions. The reported events were analyzed and provided as annual/quarterly reports, monthly alerts, and open data search for patient safety. The results of the projects and the effects of them on medication safety were reviewed.

Results: Between 2009 and 2014, 40,831 pharmaceutical near-miss events were reported from community pharmacies. Most of them related to dispensing, for example, drug mix-up and counting error, and contained many points in common with hospital pharmaceutical departments. In the annual reports published previously, the issues such as similar drug names, high-risk drugs and inquiries about prescriptions were discussed. On the other hand, outcomes of medical adverse/near-miss event reporting system carried the contents helpful to both hospital/clinic and community pharmacy. The monthly alerts titled “Drug mix-up” and “Insufficient confirmation of incorrect prescription” were related to medication errors possibly occur at community pharmacy. In the 35th quarterly report published in 2013, the topic related to cooperation between hospital/clinic and community pharmacy was considered. Besides providing information, JCQHC held a bridging meeting in the presence of hospital/clinic and community pharmacy to improve medication safety in February 2014. Furthermore, pharmaceutical companies have used the open database of the reporting system when issuing warnings about mix-up between drugs with similar names. The projects to collect pharmaceutical near-miss event and medical near-miss/adverse event have exerted a good influence on the public.

Conclusion: The nationwide pharmaceutical near-miss event reporting system and medical near-miss/adverse event reporting system have contributed to the prevention of medication error with the safety culture growing in Japan.

References:

1) The website of the Japanese pharmaceutical near-miss event reporting system (ENGLISH): http://www.yakkyoku-hiyari.jcqhc.or.jp/contents/english/index.html
2) The website of the Japanese medical adverse/nearmissevent reporting system (ENGLISH): http://www.med-safe.jp/contents/english/index.html

ISQUA15-1407

EMERGENCE OF PERSONALIZED MEDICINE: POTENTIAL IMPACT ON HEALTHCARE QUALITY AND THE ROLE OF CLINICAL PRACTICE GUIDELINES

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Objectives: Clinical practice guidelines are expected to reduce unwarranted variations in clinical practice; variations not explained by illness, patient preference, or the dictates of evidence-based medicine (Wennberg 2004). Personalized medicine, rapidly changing the ways of clinical practice worldwide, is introducing a different type of practice variations to modern healthcare. Contrary to unwarranted variations, variations brought in personalized medicine are caused by subdividing patients by genetic as well as disease characteristics. Personalized medicine seems promising, but its potential impact on the quality of healthcare is yet to be elucidated. The aim of this study was to examine the potential impact of personalized medicine on the variations in clinical practice, and to discuss the role of clinical practice guidelines to maintain the quality of healthcare in the era of personalized medicine.

Methods: The potential impact of personalized medicine was examined from three aspects; (1) the safety of practice, (2) the quality of evidence for benefits and harms of interventions, and (3) the shared decision-making by patients and practitioners. Literature was searched for a keyword “personalized medicine” with “guideline” as publication type and 2008 to 2014 for publication year.

Results: Forty-four clinical practice guidelines were identified. For the safety of practice, the number of medical errors is expected to increase; because there is evidence that the risk of medical errors tends to increase when clinicians are inexperienced and new procedures are introduced (Weingart 2000). In addition, the number of different kinds of diagnostic and therapeutic interventions to be covered by a practitioner will increase, and the workload might raise the chance of errors as well. For the quality of evidence which is the basis of clinical practice guidelines, explorative research by observational studies might become overwhelming over the high quality randomized controlled trials, as shown by the new NIH program called Precision Medicine Initiatives, because of industrial as well as public pressures to shorten the lag time from research to practice, and also because of increased uncertainty of clinical studies with small number of eligible patients of finely subdivided disease groups. For the shared decision-making, the potential impact seems to be both positive and negative; personalized medicine might be able to give patients and practitioners a more detailed profile of risks and benefits of interventions, but at the same time, the increased number of interventions featured by new biomedical technologies might strengthen the supply-sensitive driving force, disturbing the

conscientious process of shared decision-making, which clinical practice guidelines are supposed to assist.

Conclusion: The emergence of personalized medicine will potentially impact on the quality of healthcare by affecting the safety of practice, the shared decision-making, and the quality of evidence on which clinical standards are based. Clinical practice guidelines, which provide practice standards to improve the safety of practice, and to assist the shared decisions made by patients and practitioners, should accommodate with personalized medicine by improving development methods as well as implementation strategies in the future.

References:

Weingart SN et al. (2000) Epidemiology of medical error. BMJ 320: 774-777.

Wennberg J. (2004) Practice variations and health care reform: Connecting the dots. Health Aff (Millwood). Suppl Variation: VAR 140-4.

ISQUA15-1448

ROLE OF THE PATIENT SAFETY PROMOTION FOR IMPROVEMENT OF PATIENT SAFETY IN JAPAN

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Objectives: The patient safety promotion (PSP) is a voluntary association of accredited hospitals aiming at improving patient safety. In the late 1990s, the medical accidents and near-miss events were reported successively in Japan, and worries about medical care and hospital care had been spreading among our society. In this situation, we established the PSP in order to tackle the problem by bottom-up approach. JCQHC has provided support as secretariat for the PSP.

Methods: We established the PSP in 2003. Before its establishment a research group was organized in 2001, which comprised 48 hospital directors and the person in charge of medical safety. Then, from the standpoint of supporting the spontaneous improvement for the patient safety, the PSP defined its task as follows: 1) collecting and analyzing serious or perceptive errors in medical care; 2) investigating and researching; 3) promoting the result of analysis/research via seminars/forums and journals; 4) consulting or advising to the members; and 5) providing suggestions/requesting to stakeholders.

Results: In the beginning, the PSP had 550 accredited hospitals in 2003 and the membership hospitals shared their accident reports each other for discussion. Later in 2005, it had 1050 hospitals, as the on-site medical workers became highly interested in patient safety.

However, around the same time, the membership hospitals did not tend to share their concrete accident experiments, as they were afraid of being accused of the accident in the future. In response to the situation, the PSP changed gradually its methodology from discussing individual accidents to setting some missions or focusing the themes, which help the hospitals reduce their problems or risks.

Today, over 1300 accredited hospitals participate in the PSP. The PSP has a steering committee and some task forces. Each task force makes annual plan and implements it based on each mission. Task forces consist of various practitioners, who are selected by their careers and job types. Each task force decides how to summarize the discussion and how to publish final products. These days, the needs of educational programs are rising and some forces actively develop and provide some instruction for medical staffs.

In FY 2014, concrete outcomes are as follows: held 7 seminars and 4 forums on various themes, published 5 journals, made the educational movie about safe patient transfer, and issued the suggestion about the alarm fatigue.

Conclusion: The PSP has 2 characteristic points: 1) activities are based on spontaneous membership hospitals; 2) it is not-for-profit association, and financially covered by membership fee. Thus, any hospital can participate in this association if hospital agrees with the purpose, ”Promote patient safety”.

The PSP leads the activity about to improve patient safety in Japan.
However, the uneven distribution of the participants depending on the region, the number and the type of beds has become a serious issue in the past several years. So, we assume that it is essential to tackle the problem through grasping and dealing with hospitals and/or social needs.