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厚生労働省
Ministry of Health , Labour and Welfare

Abstracts and Speakers

3rd Global Ministerial Summit on Patient Safety 2018

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Introduction

Katsunobu Kato

Minister of Health, Labour and Welfare, Japan

As Japan's Minister of Health, Labour and Welfare, I would like to welcome you all to the Third Global Ministerial Summit on Patient Safety. It is my great pleasure to host the Summit, and also to welcome so many distinguished experts in patient safety, high-level government delegations, policymakers, and representatives from professional associations, civil organizations and other non-governmental organizations.

The movement of patient safety, which is the theme of this Summit, emerged from a report called "To Err Is Human" published by the Institute of Medicine in 2000. The report challenged the conventional view that medical accidents are mainly caused by the incompetence or negligence of people, and highlighted that harm caused by human error is far more common than previously thought. Since then, great efforts have been made in each country to solve the problems.

The first Global Ministerial Summit on Patient Safety was held in London two years ago. By sharing the importance of patient safety, the Summit gave momentum to the global movement. The second Summit, held in Bonn last year, strengthened the patient safety movement by presenting various practical safety measures. At this third Summit, firstly we would like to focus on the importance of patient engagement by reflecting more patients' views on health service delivery. Secondly, we would like to consider the importance of patient safety in promoting universal health coverage (UHC). By sharing these concepts among the participants, we aim to raise the global patient safety movement to the next stage.

There are two approaches to engaging patients and reflecting their views in order to attain safe and high-quality health services. One is patients' engagement for their own benefit. When medical staffs give their patients sufficient information about the treatment, the patients will be motivated to engage. This will enhance the dialogue and mutual understanding between the patient and the medical staff, and thus improve the quality of the treatment. The other approach is patients' engagement in discussions on the health system. We must recognize the importance of reflecting the views of patients and citizens on healthcare policies and measures. For example, cancer is such a common disease in Japan, estimated to affect 50% of the citizens. It is a legal requirement in Japan for representatives of cancer patients to be involved in designing the cancer control plan. Indeed, the Ministry released a new plan in March reflecting their views. Based on this plan, we will promote patient-centered cancer control measures. For example, hospitals providing highly specialized cancer treatment will be required to take specific actions for patient safety. Another example is how we manage the Medical Accident Investigation System which was established in 2015. The representatives of patients and bereaved families served as members of the Preparatory Committee, and are now on the Governing Board of the System. Their opinions are helping to deliver safe and high-quality healthcare.

In this third Patient Safety Summit, I look forward to productive discussions on the importance of patient safety in promoting UHC. Japan achieved full health insurance coverage of the nation in 1961, and has since been improving its health system. Around 2000, however, there was a series of fatal medical accidents in large hospitals which were caused by rather basic human errors. These incidents became a turning point in our health policies, and we have placed patient safety as one of our top priorities. Various hurdles and issues remain because it is extremely challenging to add patient safety measures to the already-established health system. In this Summit, many low- and middle-income countries are participating, and I understand each country is making efforts to establish or reorganize its health system to achieve UHC. Such countries could benefit by learning from our past mistakes and experience, and should establish a new system that incorporates patient safety measures at an early stage. I strongly hope such efforts will bring the benefits of safe and high-quality health services to the people in each of our countries.

This Summit is being held in Asia for the first time, with many new participating countries. I sincerely hope that it will accelerate and consolidate the global momentum toward patient safety.

Opening Statement

Toshihiko Takeda

Ministry of Health, Labour and Welfare, Japan

Speaker Information:

Academic Record
March 1983: Graduated from Faculty of Law, University of Tokyo, Japan

Professional Experience
July 2017 – Present Director-General, Health Policy Bureau
June 2016 – Director-General, Pharmaceutical Safety and Environmental Health Bureau
October 2015 – Director-General for Policy Planning and Evaluation
July 2014 Councillor, Minister's Secretariat
September 2012 Councillor, Minister's Secretariat, Fire and Disaster Management Agency
August 2011 Counsellor, Minister's Secretariat
July 2010 Director, General Affairs Division, Health Insurance Bureau
July 2009 Director, Medical Institution Management Support Division, Health Policy Bureau

July 2008 Director, National Health Insurance Division, Health Insurance Division
September 2006 Director, Economic Affairs Division, Health Policy Bureau
July 2004 Director, Health Insurance Division, Administration Department, Social Insurance Agency
April 1983 Ministry of Health Labour and Welfare, Japan

Special Remarks

Angel Gurría

OECD

Speaker Information:

Angel Gurría was born on May 8th, 1950, in Mexico. Mr Gurría came to the Organisation of Economic Co-operation and Development (OECD) following a distinguished career in public service. As Mexico's Minister of Foreign Affairs (Dec. 1994-Jan. 1998), he made dialogue and consensus-building one of the hallmarks of his approach to global issues. From January 1998 to December 2000, he was Mexico's Minister of Finance and Public Credit, ensuring a smooth economic transition between different administrations. As Secretary-General of the OECD since 2006, Mr. Gurría has firmly established the Organisation as a pillar of the global economic governance architecture including the G7, G20 and APEC, and a reference point in the design and implementation of better policies for better lives. He has broadened OECD's membership with the accession of Chile, Estonia, Israel, Latvia and Slovenia, and has made the Organisation more inclusive by strengthening its links with key emerging economies. Under his watch, the OECD is leading the effort to reform the international tax system, and to improve governance frameworks in anti-corruption and other fields. He has also heralded a new growth narrative that promotes the well-being of people, including women, gender and youth, and has scaled up the OECD contribution to the global agenda, including the Paris Agreement on Climate Change and the adoption of the Sustainable Development Goals. Mr. Gurría holds a B.A. degree in Economics from UNAM (Mexico) and a M.A. degree in Economics from Leeds University (United Kingdom). He is married and has three children.

Opening Session

Ara W. Darzi

Imperial College London, U.K.

Speaker Information:

Professor Darzi is Director of the Institute of Global Health Innovation at Imperial College London. He also holds the Paul Hamlyn Chair of Surgery at Imperial College London, and the Institute of Cancer Research and is Executive Chair of the World Innovation Summit for Health in Qatar. He is a Consultant Surgeon at Imperial College Hospital NHS Trust and the Royal Marsden NHS Trust.

Professor Darzi leads a large multidisciplinary team across a diverse portfolio of academic and policy research. He has published over 1,000 peer-reviewed research papers to date, developing his status as a leading voice in the field of global health policy and innovation. In recognition of his achievements, Professor Darzi was elected a Fellow of the Academy of Medical Sciences, an Honorary Fellow of the Royal Academy of Engineering, a Fellow of the Royal Society and a foreign associate of the Institute of Medicine.

In 2002, he was knighted for his services in medicine and surgery, and was introduced to the United Kingdom's House of Lords as Professor the Lord Darzi of Denham in 2007. He has been a member of the Privy Council since June 2009 and was awarded the Order of Merit in January 2016.

Keynote Lecture 1

Chair: Yoshitake Yokokura

World Medical Association

Chair Information:

Yoshitake Yokokura, M.D.,Ph.D.
President, World Medical Association
President, Confederation of Medical Associations in Asia and Oceania
President, Japan Medical Association

Dr. Yoshitake Yokokura graduated from the Kurume University School of Medicine in March, 1969, and worked for the surgery department of the University. After that he worked for the surgery department of the Detmold Hospital in West Germany for two years (1977-79) He has been President of the Yokokura Hospital since 1990.

He took office as President of the Fukuoka Prefecture Medical Association in 2006. He was elected as President of the Japan Medical Association in April 2012. He also served Council Member of the World Medical Association (WMA) from 2010 to 2016. He serves as President of the WMA (2017-18) and President of the Confederation of Medical Associations in Asia and Oceania (2017-18).

He is serving as a member of the following committees of the Japanese government.

Medical Ethics Council of the Ministry of Health, Labor and Welfare, Central Disaster Prevention Council, National Council for Disaster Preparedness and Hideyo Noguchi Africa Prize Committee, Japan Industrial Conference for Next-generation Healthcare of the Ministry of Economy, Trade and Industry.

Dr. Yokokura has been actively involved in the program development of the Taro Takemi Program in International Health at the Harvard T H Chan School of Public Health for years to provide opportunities for the researchers from the developing countries to study at this program. The Japanese committee chaired by Dr. Yokokura set up the donation program for the middle career researchers especially from the African regions.

In the cultural area, he has been recently appointed as “2025 World Expo Special Luring Envoy” to Osaka.

Chair: Guenther H. Jonitz

Berlin Chamber of Physicians, Germany

Chair Information:

born 1958 in Munic, Germany. Specialist in surgery 1994; PhD 1996; since 1999 President of the Berlin Chamber of Physicians; member of the board of the German Medical Association, chairing the board for quality and safety; technical advisor to the German Ministry of Health on Patient Safety since 2006; founding member of the German Network for Evidence-based Medicine (2000), initiator and founding member of the board of the German Coalition for Patient Safety (2005). Promoting value-based health care in German speaking countries.

Yasuhiro Suzuki

Ministry of Health, Labour and Welfare, Japan

Speaker Information:

Dr. Suzuki was born in 1959. He graduated from School of Medicine, Keio University (MD) in 1984 and trained as neurologist. He received PhD for public health from Keio University in 1996 and two Master's degrees from the Harvard School of Public Health (MPH in 1999 & MSc in 2000).

Dr. Suzuki has a professional career at the Ministry of Health, Labour and Welfare (MHLW), Japan for 30 years covering infectious diseases, mental health, environmental health, food safety, international health, ageing & health, and health research policy. He also worked for the World Health Organization as Executive Director for Social Change & Mental Health, later for Health Technology and Pharmaceuticals (covering vaccines, immunization and biologicals) from 1998 to 2002.

He is currently the Chief Medical & Global Health Officer, Vice-Minister for Health in MHLW from July 2017.

Dr. Suzuki is married and has one daughter.

Victor J. Dzau

MD, US National Academy of Medicine

Speaker Information:

Victor J. Dzau is the President of the National Academy of Medicine (NAM), formerly the Institute of Medicine (IOM) and Vice Chair of the National Research Council. Dr. Dzau is Chancellor Emeritus and James B. Duke Professor of Medicine at Duke University and the past CEO of the Duke University Health System. Previously, Dr. Dzau was the Hersey Professor and Chairman of Medicine at Harvard Medical School, as well as Chairman of the Department of Medicine at Stanford University.

He is an internationally acclaimed leader and scientist whose work has improved health care in the United States and globally. His seminal work in cardiovascular medicine and genetics laid the foundation for development of the class of lifesaving drugs known as ACE inhibitors, used globally to treat hypertension and heart failure. Dr. Dzau pioneered gene therapy for vascular disease and was the first to introduce DNA decoy molecules to block transcriptions in human in vivo. His pioneering research in cardiac regeneration led to the Paracrine Hypothesis of stem cell action and his recent strategy of direct cardiac reprogramming using microRNA.

In his role as a leader in health care, Dr. Dzau has led efforts in innovation to improve health, including the development of the Duke Translational Medicine Institute, the Duke Global Health Institute, the Duke-National University of Singapore Graduate Medical School, and the Duke Institute for Health Innovation. He has served as a member of the Advisory Committee to the Director of the National Institutes of Health (NIH), chaired the NIH Cardiovascular Disease Advisory Committee and currently chairs the NIH Cardiovascular Stem Cell Biology and Translational Consortia. He has served on the Board of Health Governors of the World Economic Forum. Currently he is a member of the Board of the Singapore Health System, member of the Health Biomedical Sciences the International Advisory Council of Singapore and Advisory Council of the Imperial College Health Partners, UK.

Under his direction, the National Academy of Medicine advances science and improves health by providing objective, evidence-based guidance on critical issues. His foresight in translation of research into medicines, policies and creative solutions for human health issues is a great asset to the Academies and to the public at large. Since arriving at the National Academies, Dr Dzau has led important initiatives such as the Commission on a Global Health Risk Framework; the Human Gene Editing Initiative; and Vital Directions for Health and Health Care, and the Grand Challenges in Healthy Longevity.

Among his many honors and recognitions are the Max Delbreck Medal from Charite, Humboldt and Max Plank, Germany, the Distinguished Scientist Award from the American Heart Association, Ellis Island Medal of Honor, and the Henry Freisen International Prize. In 2014, he received the Public Service Medal from the President of Singapore. He has been elected to the National Academy of Medicine, the American Academy of Arts and Sciences, the European Academy of Sciences and Arts, and Academia Sinica. He has received 13 honorary doctorates.

Panel Discussion 1

Patient Safety Culture

Chair: Donald M. Berwick

Institute for Healthcare Improvement, U.S.A.

Chair Information:

Donald M. Berwick, MD, MPP, FRCP, KBE, is President Emeritus and Senior Fellow at the Institute for Healthcare Improvement (IHI), an organization that Dr. Berwick co-founded and led as President and CEO for 18 years. He is one of the nation's leading authorities on health care quality and improvement. In July, 2010, President Obama appointed Dr. Berwick to the position of Administrator of the Centers for Medicare and Medicaid Services (CMS), which he held until December, 2011. A pediatrician by background, Dr. Berwick has served as Clinical Professor of Pediatrics and Health Care Policy at the Harvard Medical School, Professor of Health Policy and Management at the Harvard School of Public Health, and as a member of the staffs of Boston's Children's Hospital Medical Center, Massachusetts General Hospital, and the Brigham and Women's Hospital. He has also served as vice chair of the U.S. Preventive Services Task Force, the first "Independent Member" of the Board of Trustees of the American Hospital Association, and chair of the National Advisory Council of the Agency for Healthcare Research and Quality. He is an elected member of the American Philosophical Society and of the National Academy of Medicine (formerly the Institute of Medicine). Dr. Berwick served two terms on the IOM's governing Council and was a member of the IOM's Global Health Board. He served on President Clinton's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry. He is a recipient of numerous awards, including the 1999 Joint Commission's Ernest Amory Codman Award, the 2002 American Hospital Association's Award of Honor, the 2006 John M. Eisenberg Patient Safety and Quality Award for Individual Achievement from the National Quality Forum and the Joint Commission on Accreditation of Healthcare Organizations, the 2007 William B. Graham Prize for Health Services Research, the 2007 Heinz Award for Public Policy from the Heinz Family Foundation, the 2012 Gustav O. Lienhard Award from the IOM, and the 2013 Nathan Davis Award from the American Medical Association. In 2005, he was appointed "Honorary Knight Commander of the British Empire" by Queen Elizabeth II, the highest honor awarded by the UK to non-British subjects, in recognition of his work with the British National Health Service. Dr. Berwick is the author or co-author of over 160 scientific articles and six books. He also serves now as Lecturer in the Department of Health Care Policy at Harvard Medical School.

Chair: Chris A. Power

Canadian Patient Safety Institute

Chair Information:

What began as a desire to help those in need 35 years ago has evolved into a mission to improve the quality of healthcare for all Canadians. Chris Power's journey in healthcare began at the bedside as a front-line nurse. Since then, she has grown into one of the preeminent healthcare executives in Canada. Her experiences, her success, and her values have led her to the position of CEO of the Canadian Patient Safety Institute.

Previously, Chris served for eight years as president and CEO of Capital Health, Nova Scotia. She holds significant governance roles including Chair of the Canadian Association for Health Services & Policy Research, Co-Chair of CHLNet and Board member of Colleges & Institutes of Canada.

Most recently Chris participated as a member of the federal advisory panel on healthcare innovation. Her love of family and gift of song keep her grounded in all that she does.

Michael A. Durkin

Institute of Global Health Innovation, Imperial College London, U.K.

Time to Move to a Cultural Era in Patient Safety of Values, Ethics and Leadership at Every Level

Abstract:

Harm within the NHS in the UK is measured at a local and at a national level such that we have a positive reporting culture that is identifying a system that may be open, permissive, and supportive.

The burden of harm that is identified is reducing but not at an appropriate pace or scale. We need patients to be equal partners in our journey to reduce harm as they can shed light on the burden of harm that we as professionals have often failed to see.

The era of safety measurement has brought us knowledge of the known and emerging harms; Falls, Pressure Ulcers, VTE, Infection and Sepsis, Medication Error, Suicides while in Care, Anti-Microbial Resistance and the rise of GM negative infections, Maternal Morbidity and Neonatal Injury.

We are however only just starting to recognize the underlying barriers to safety Improvement such as lack of transparency, sharing of data, a true system of candour from professionals and organisations, and the importance of a truly supportive safety culture, whereby learning from what goes right is as important as learning from harm.

The next years must be a true educational era of value, ethics and leadership at every level in support of a cultural shift to move away from the Professional identity back to an Ethical identity whereby organizational and personal values are of equal importance as fiscal control; and to reduce a reliance on hierarchical expertise and to support the patient being at the heart of their care and in control of their health and care management and outcome.

Keywords:

Patient Safety, Value, Values, Ethics, Leadership, Measurement, Harm, Transaparency, Candour,Trsut, Honsety, Respect, Improvement

Speaker Information:

Dr Mike Durkin was the NHS National Director of Patient Safety from 2012 to 2017 and is the Senior Advisor on Patient Safety Policy and Leadership at the Institute of Global Health Innovation. He has held management, teaching and research appointments in London, Bristol and Yale Universities culminating as the Executive Medical Director of the NHS across the South of England. He was the UK National Director for VTE and is an appointed Expert by ISQua. He led the development of the National Patient Safety Alerting System, the 15 Patient Safety Collaboratives across England and the Q Fellowship to build a community of 5000 quality improvers. He convened the Berwick Advisory Board in 2013 to advise on improving the safety of patients in England and in 2015 he was commissioned to Chair the Expert Advisory Group to advise on the establishment of the Healthcare Safety Investigation Branch.

Hardy Müller

German Coalition for Patient Safety - Aktionsbündnis Patientensicherheit e.V. (APS)

German Coalition for Patient Safety - the Story Behind Safety Culture

Abstract:

The German Coalition for Patient Safety - in German "Aktionsbündnis Patientensicherheit e.V. (APS)" is a non-profit association of individuals and organisations to improve patient safety. The APS was established in 2005 and is overseen by an honorary board. The presentation covers activities and ongoing projects of the APS. Over ten years of activity has shown that independence is an important prerequisite for asking the difficult but necessary questions often associated with patient safety. However, the precarious financing through membership fees and donations is challenging. Basic funding is required to expand and, at the same time, to keep the APS independent.

The extent of adverse events in Germany cannot be rated differently than in comparable countries. Nevertheless, the scientifically established prevalence of these adverse events leads to great public controversy over the extent of the problem. This is often a result of unclear terminology and a poor distinction between epidemiological and legal perspectives in the public debate.

The International Patient Safety Day, initiated by the APS, will take place for the fourth time in Germany this year. We welcome the introduction of a "World Patient Safety Day" and look forward to sharing our experiences. The imperative *primum non nocere* is one of the oldest medical-ethical obligations. It is important we give more weight to this imperative in addressing the current demands of patient safety. To this end we have articulated ethical principles for patient safety. These will be presented in detail and we hope that they can be further developed and adapted by other organisations. A topic for a World Patient Day?

Keywords:

epidemiology, adverse events, ethics, association, terminology, international patient safety day

Speaker Information:

After studying anthropology, sociology and psychology Hardy Müller started his career as a research associate focusing on 'Regional Mortality Differences'. Since 1993 he has worked in the statutory health insurance in various senior positions. Initially he established a health reporting system using routine data and organized the health care management of the biggest German insurance company. Later he developed and implemented strategies for contracts with healthcare providers.

From 2009 to 2011 Hardy Müller was spokesperson for the Department "Patient Information and Participation" in the German Network for Evidence-based Medicine e.V. and in 2010 he was a Member of the Faculty of the Summer Institute on Informed Patient Choice, Dartmouth College, Hanover, USA.

Hardy Müller is a certified healthcare risk manager. He is a member of various advisory boards, e.g. the technical advisory board of the research association "Leibniz Health Technologies". Currently, Hardy Müller is a senior advisor at the TK Scientific Institute of Value and Efficiency in Healthcare (WINEG) and the Honorary Managing Director at the German Coalition for Patient Safety (Aktionsbündnis Patientensicherheit e.V.).

Ton Thanh Tra

Cho Ray hospital, Ho Chi Minh City, Vietnam

Kaizen Activities at a Public Hospital in a Developing Country

Abstract:

Cho Ray is a tertiary teaching hospital, Located at Ho Chi Minh City, Vietnam. Kaizen activitives have been applied for a long time but the strong and most activities have been established when Ministry of health had the regulation on improving health care services in 2013. At that time, all hospitals must have resources for Kaizen activities. Since 2016, thanks to supporting from Japan International Cooperation Agency (JICA) experts, we have applied Kaizen in: Antimicrobial stewardship program, Incident report system, 5 S activities, Respiratory support activities, patient safety training and many procedure compliances audit at Cho Ray hospital. The initial results showed that Kaizen activities were suitable with our condition and should be done at all hospitals. We are continuing to improve our quality of services to meet the customers' demand. The lessons learnt from Kaizen activities were: Leadership, encouragement, training and audit regularly.

Keywords:

Kaizen, hospital quality management, patient safety, Cho Ray hospital

Speaker Information:

Ton Thanh Tra , MD, PhD. Emergency doctor, Head of Quaity management, Cho Ray hospital, Ho Chi Minh City, Vietnam. I graduated Medical University in 1997, Master degree in 2009 and PhD degree in 2018 at Univerisity of Medicine and Pharmacy at Ho Chi Minh City, Vietnam. Working at Cho Ray hospital since 2001. From 2001 - 2007: Physician at Respiratory department. From 2007 - 2013: Emergency doctor. From 2013 to now: Emergency doctor, Head of Quality management department. I have published over 30 articles related to Emergency medicine, quality management and patient safety. Now, I am also the invited lecturer at University of Medicine and Pharmacy, Ho Chi Minh City, Vietnam.

Yutaka Aso

Chairman, Aso Corporation, Japan

Patient Safety Through Kaizen Activities

Abstract:

1. The background of Iizuka Hospital establishment and thoughts on Iizuka Hospital
   - The spirit of establishment in 1917: ”To bring together skilled physicians, and provide the best in medical treatment and provision of medicine for the people of the region”.
   - Our goal is the hospital with the most sincere medical treatment in Japan.
   - We launched our TQM (Total Quality Management) activities in July 1992. The activities are implemented under the theme of better quality and services in healthcare and management.
2. Efficiency by Kaizen activities (eliminating waste) leads to making the mental elbowroom
   - The mission of “We deliver the best” leads to hospital employee satisfaction, and hospital employee satisfaction leads to patient satisfaction.
   - The leader clearly shows this mission, leads the team.
   - We have provided three approaches by which hospital staff can work on Kaizen activities according to the purpose and timeline: the existing QC Circle Activities, the Kaizen Workshop, and the Everyday Kaizen.
3. Example of improving patient safety through Kaizen activities
   - Nursing care system “Lean Workcell Nursing”
4. Kaizen activities has an effect on patient safety

   AIH has been developing TQM through continuous improvements by hospital staffs. In recent healthcare services, which involve complex connections among processes involving various medical specialists, we think that TQM could be an effective tool for every hospital to improve the quality and safety of the healthcare system. The ability to understand the process cultivated through Kaizen activities and the ability to solve problems are connected to the effective resolution of the problem such as the incident. Team work is a Japanese strong competitiveness, once we share the mutual vision and target it brings safety culture into the hospital.

Keywords:

kaizen, safety, quality, custemer satisfaction, hospital employee satisfaction, leader

Speaker Information:

Yutaka Aso served as the CEO of the Aso Corporation from 1979 to 2010 and as Chairman from 2010. This company owns the Iizuka Hospital. Iizuka Hospital has 1000+ beds and fulfills the role of the core hospital serving a population of over 400,000 people. The hospital will celebrate its 100th anniversary in 2018. He leads the hospital following the mission of “We deliver the best” even now.

He is also the Chairman of the Kyushu Economic Federation since 2013 and has a strong commitment to this mission: “Move Japan forward from Kyushu!”.

He is also the author of several books about hospital management.

Ikuko Toyoda

IMS Rehabilitation Center Tokyo Katsushika Hospital, Japan

Positive Impact on Patient Engagement - What I Have Undergone as a Bereaved Family -

Abstract:

I lost my beloved son in 2003 in a medical accident.
At first, the hospital insisted that they had done their best. However, thanks to a whistle-blower, a newspaper revealed that there had been some critical systematic clinical error in the hospital. At the time, my grief and anger were far beyond words. I held the hospital against.
However, gradually I came to feel that indulging in grief and anger would not lead anywhere, so I summoned up the courage to join a workshop. That led me to a fateful encounter with Dr. Yoichi Shimizu, Director of Shin-Katsushika Hospital. He offered me a position as a safety manager at his hospital. I was surprised by the offer and assumed that I could not fulfill the role, as I had suffered bereavement by a medical accident and I had no medical background. However, my strong desire to know what is happening in the medical world overcame my reluctance, so I started. This happened 18 months after my son's death.
At the hospital, in 2006, my first step was to organize a workshop to facilitate dialogue between medical staff and patients. In 2012, the activity was formalized as an NPO called "KAKEHASHI", meaning "bridge". The main activities of the NPO are to serve as a bridge between patients, families and medical staff.
Based on my experience, I also give my opinions on national policies by serving as a member of several national committees.

Keywords:

Patient Support / Family Support / Second Victim / Second Victim Support / Patient Councelling / Patient Councelling Counter / Medical Accident Investigation System / Medical Accident Reporting System / Medical Dialogue / Medical Dialogue Facilitator

Speaker Information:

Present: Director of Patient Safety Unit, IMS Rehabilitation Center Tokyo Katsushika Hospital
Past activities:
Member of the "Study group on the establishment of a no-fault compensation system to improve medical quality" for the Ministry of Health, Labour and Welfare (MHLW)
Member of the Advisory Group for MHLW on "Scheme for investigating medical accidents"
Member of "Study on method for investigating deaths associated with medical treatment," Scientific Research 2014
Member of "Enforcement of medical accident investigation system" Review Committee, MHLW
Member of Drafting Committee for "Guidance on investigating hospital accidents," Medical Safety Promotion Committee, Japan Hospital Association
Current activities:
Chairman of NPO KAKEHASHI (Bridge), connecting patients, families and medical staff
Chief of Secretariat for Medical Safety Liaison Council from the patient's perspective
Member of Cause Analysis Committee, Obstetric Medical Compensation System, Japan Council for Quality Health Care
Member of Comprehensive Investigation Committee, Medical Accident Investigation System, Japan Medical Safety Investigation Agency

Jeffrey Braithwaite

Australian Institute of Health Innovation, Macquarie University

Safety-I, Safety-II and the Resilience of Health Care

Abstract:

Internationally health systems have invested significant resources in the development of policies and programmes to reduce rates of adverse events, yet despite these concerted efforts to make health care safer, rates of harm seem to have flatlined at approximately ten per cent. From an economic standpoint, ten per cent has substantial implications; harm due to medication safety alone costs Australia approx. AUD$1.2 billion (¥98.9 billion) annually.

Improvements in patient safety have been difficult to sustain and spread, partly due to limitations in our thinking. The current approach to patient safety, labelled Safety-I, focuses on identifying when things go wrong after an incident has occurred, and aims to prevent mistakes from reoccurring. This find-and-fix type model is linear in nature and often fails to recognise the complexities of health care. By realigning our focus and giving attention to efforts which enable things to go right, labelled Safety-II, we begin to appreciate the resilience of health care, and that despite numerous challenges, everyday performance succeeds more often than it fails.

A resilient health system is one which flexes and adapts to provide good care under a variety of circumstances. The key to the Safety-II approach is allowing people to learn from everyday clinical work which succeeds as well as harms. It means facilitating work flexibility, and actively trying to increase the capacity of clinicians to deliver care more effectively. During the course of the presentation I endeavour to sharpen understanding of why work-as-imagined is different to work-as-done and discuss the key concepts of complexity science and resilient health care in a patient safety context.

Keywords:

Patient safety; Resilience; Complexity science ; Implementation science; Diffusion; Sustainability; Safety-I; Safety-II

Speaker Information:

Professor Jeffrey Braithwaite, BA, MIR (Hons), MBA, DipLR, PhD, FAIM, FCHSM, FFPHRCP (UK), FAcSS (UK), Hon FRACMA, FAHMS is Foundation Director of the Australian Institute of Health Innovation, Director of the Centre for Healthcare Resilience and Implementation Science, and Professor of Health Systems Research, Faculty of Medicine and Health Sciences, Macquarie University, Sydney, Australia. He has appointments at six other universities internationally including the Canon Institute for Global Studies in Japan; he is a board member and President Elect of the International Society for Quality in Health Care (ISQua) and advisor to the World Health Organisation (WHO) and Global Ministerial Summit on Patient Safety.

Panel Discussion 2

Patient Safety in Ageing Society

Chair: Tomonori Hasegawa

Toho University School of Medicine, Japan

Chair Information:

Tomonori HASEGAWA, M.D., Ph.D. is professor of the Department of Social Medicine, Toho University School of Medicine. He graduated from Tokyo University School of Medicine in 1985, and had residency at Tokyo University Hospital (1985-1987). His academic activities cover health policies and performance evaluation of health systems. He published more than 170 reviewed articles and 90 books (including participation as co-author). He was engaged in health sector reform in Japan as an advisory member of the Cabinet Office from 2001 to 2010. He is an executive board member of the Japan Council for Quality Health Care and is responsible for hospital accreditation. He is a board member of the Japanese Society of Healthcare Management (editor-in-chief of the Journal of Japanese Healthcare Management). He is/was a member of the following academic societies and committees; Japanese Society of Public Health, Japanese Society of Hygiene, Japanese Society of Transplantation (board member, chair of the ethical committee 2008-2015), Japanese Society of Hospital Administration (board member 2011-2012), Japan Organ Transplant Network (board member 2012-2015), Ministry of Labor, Health and Welfare Committee on Disclosure of Healthcare Information (2003), Committee on the Administration of Healthcare Organizations (2004), Committee on the Review of Medical Claims, Committee on the Healthcare Organization, Japan Medical Association Hospital Committee, All Japan Hospital Association Committee on Healthcare Quality Improvement, and Committee on Hospital Accreditation.

Chair: Tommaso Bellandi

Northwest Trust of the Tuscany's public Health Service, Italy

Chair Information:

Tommaso Bellandi is a certified Ergonomist/Human Factors Engineer (Eur.Erg.). He graduated at the University of Siena in 2001 in Communication Science, he obtained a Master in Ergonomics and Human Factors in 2003 and a PhD in ICT in 2006 at the University of Florence. During his PhD he attended study visits at the Clinical Safety Research Unit of the Imperial College in London and at the Danish Society for Patient Safety in Copenhagen.

He is currently Director of Patient Safety at the Northwest Trust of the Tuscany's Health Service, which is a big public organization with around 12 thousands employees, providing health and social services to 1.5 millions people in the Italian provinces of Lucca, Pisa, Livorno and Massa-Carrara.

He previously worked from 2004 to January 2018 at the Centre for Clinical Risk Management and Patient Safety, located at the Department of Health of the Tuscany Region in Florence, where he was deputy director and responsible for the Reporting and Learning System. He has been responsible for quality and safety of the Regional Organization for organs and tissues donation and transplantation, auditor of the National Centre for Transplantation and surveyor of accreditation in Tuscany.

He is Advisor and former Chair of the WHO Collaborating Centre on human factors and communication for the delivery of safe and quality care, located in Florence.

He is Adjunct Professor of ergonomics and patient safety at the University of Florence (I) and at the Sant'Anna School of Advanced Studies in Pisa (I). He collaborated for training and research purposes with the Imperial College (UK), Universidad Catolica de Cile, Università della Svizzera Italiana (CH), Swiss Foundation for Patient Safety (CH), Italian Foundation for Patient Safety (I).

He is author of 93 publications on Italian and international journals, books and proceedings of conferences on patient safety, human factors and communication in healhcare. He is associated editor of the journals Transactions of Healthcare Systems Enginnering and Journal of Patient Safety and Risk Management.

He is member of the Council of the Italian Ergonomics Society, with the role of president of the national assessment board of professional ergonomists and member of the Council of the Centre for the Registration of the European Ergonomists. He is also in the board of the Italian Society for Safety and Quality in Transplantation.

Albert W. Wu

Johns Hopkins University, U.S.A.

Patient Safety in an Ageing World

Abstract:

Most countries have rising life expectancy and an ageing population. Older people are venerated across the globe. However, they utilize a disproportionate amount of health care, and are at increased risk for adverse events in hospital and outpatient settings. These events are more likely to result in permanent disability and death than for younger patients, and are associated with increased costs. In a US study, 19% of patients 65 or older experienced at least one adverse event, 62% of these resulting from outpatient care. In hospitals, elderly patients have a higher incidence of preventable events related to medical procedures, adverse drug events, and falls. Factors at multiple levels of the system contribute to the increased incidence. These include patient factors like decreased physiologic reserve, cognitive decline, and multiple chronic conditions. Health care factors include polypharmacy, medication errors, overly aggressive treatment, poor communication with patients and families, and lack of coordination within the healthcare team. Societal factors include poverty, isolation, and inadequate long term care. Patient safety in long term care is a special case as a growing number of people require care in skilled nursing facilities, inpatient rehabilitation facilities or long-term care hospitals. Some solutions have been proposed to improve patient safety for older people. The most successful tend to be multidisciplinary and multifactorial, aiming at different levels of the healthcare system. The healthcare workforce is also ageing. Therefore, a related issue is what are the best ways to support ageing health professionals to prolong their working life.

Keywords:

Patient safety, elderly, falls, adverse drug event, long term care, health care workers

Speaker Information:

Albert W. Wu is a practicing general internist and Professor of Health Policy & Management at the Johns Hopkins University Bloomberg School of Public Health, with joint appointments in Epidemiology, International Health, Medicine, Surgery, and Business. He is director of the Johns Hopkins Center for Health Services & Outcomes Research, Center for Meaningful Measures of the Armstrong Institute for Patient Safety and Quality, PhD in Health Services Research, and online Masters of Applied Science in Patient Safety & Healthcare Quality. He has studied patient safety since 1988, and has published over 400 papers and two books. He coined the term “Second Victim,” and co-directs the RISE staff support program at the Johns Hopkins Hospital. He was a member of the Institute of Medicine committee on medication errors, and Senior Adviser for Patient Safety to WHO in Geneva. He is Editor-in-Chief of the new Journal of Patient Safety and Risk Management.

Siu F. LUI

The Chinese University of Hong Kong, Jockey Club School of Public Health and Primary Care and Jockey Club Insititue of Ageing

Specific Risk in Elderly People

Abstract:

To facilitate the identification of specific risk in elderly people, a proposed integrated & systematic framework is adapted from two WHO taxonomies: International Classification for Patient Safety (ICPS) and The International Classification of Functioning, Disability, and Health (ICF). The relevant elements from the IPCS to identify risk are (1) Incident Type, (2) Incident Characteristics, (3) Patient Characteristics and (4) Contributing Factors/Hazards. The Components and domains from ICF are (1) Body function/ structure, (2) Activities and participation, (3) Environmental factors and (4) Personal Factors.

The proposed integrated and systematic framework is used to identify risk in elderly people from (i) failure of body functions (aging/ illness) to participate/ execute certain activities, (ii) contributing factors (environmental, personal), and (iii) care/ treatment process resulting in harm.

This proposed framework can be applied for individual person/ patient & for different settings (Hospital, Clinic, Ambulatory care, Residential care, Home, Community), at a specific time/place setting, and during transition of care.

Some specific risks in elderly people:

Body condition (Hypothermia, Malnutrition, Dehydration)
Care/Treatment (In-coordinate care, over-treatment, under-treatment, iatrogenesis, inaccessibility to care, hospital, local resources/ service)
Misidentification (Wrong patient, Wrong treatment)
Medication (Medication error, Polypharmacy, side effect of drugs)
Fall and use of barriers, Restraints, the risk thereof
Tube feeding (misplacement)
Missing (lost)
Self harm (Suicide)
Dehumanized care (Elder Abuse)

Keywords:

Elderly, Heathlcare Risk, Risk identification framework, Patient Safety, Frialty

Speaker Information:

Currently position: Clinical Professional Consultant (part time) at the Division of Health System, Policy and Management, The Jockey Club School of Public Health and Primary Care, and Adjunct Professor, Jockey Club Institute of Ageing, Chinese University of Hong Kong.
He was the Consultant (Quality and Risk Management) for Hospital Authority (HA) Hong Kong till 2012. He was the Chairman of HA Central Committee for Quality and Safety and Central Committee for Patient Relations and Engagement.
He has contributed significantly to the development of Quality, Safety and Patient relations.
He has developed and implemented many programs, including HA Drug Formulary, Clinical IT systems, Incident reporting (AIRS), Sentinel event reporting, 2D-barcode for correct patient identification, Medication safety, Hospital Accreditation, Patient experience survey and applied mediation.
He was the co-convenor of the Program Advisory Committee for the BMJ/IHI International Forum on Quality and Safety in Healthcare: Asia for 2015 and 2016.
This presentation was prepared with colleagues from Jockey Club School of Public Health and Primary Care & Jockey Club Institute of Ageing of The Chinese University of Hong Kong, HKSAR and the Geriatric Division & Quality and Safety Department of New Territories East Cluster, Hospital Authority, Hong Kong.

Midori Hirai

Kobe University, Japan

Medication Safety Challenges in Older Adults

Abstract:

Elderly people often suffer from multiple diseases with age. In Japan, disease-specific guidelines have been developed and are used for routine medical practice. The category of prescription medicine is increasing, according to abnormalities of symptoms and laboratory data of patients. A further problem is the so-called "prescription cascade", which means misinterpreting the harmful effects of drugs as the emergence of new diseases and adding further prescription drugs. As the number of prescription drugs increases, the possibility of adverse effects and drug interactions appearing increases. To maintain medical safety, the types of prescription medicine should be minimized. Currently in Japan, the "Senior citizens' safe drug treatment guidelines" issued by the Japan Geriatrics Society is becoming a best-seller as the elderly become more interested in multiple drug combinations. The prescription of more drugs than is necessary or the prescription of potentially inappropriate drugs is called "polypharmacy". How to proceed with "prescription review" to correct such polypharmacy has become a central concern for ensuring proper medical care for the elderly. Optimizing medication through prescription review or deprescribing is critical in managing chronic conditions, avoiding adverse effects and improving outcomes.

Keywords:

elderly people, prescription cascade, polypharmacy, prescription review, deprescribing, avoiding adverse effects

Speaker Information:

Academic record

March 1974 Graduated from Department of Pharmaceutical Sciences, Kyoto University (Bachelor of Pharmaceuticals)
March 1985 Graduated from Kobe University School of Medicine (Bachelor of Medicine)
March 1992 Completed doctoral course of Graduate School of Medicine, Kobe University and acquired PhD

Qualifications

October 1974 Acquired pharmacist license (No. 145990)
June 1985 Acquired medical doctor's license (No. 294695)

Career

April 1990 Department of Hospital Pharmacy, Kobe University School of Medicine
August 1990 Faculty of Hospital Pharmacy, Kyoto University Medical School
April 1995 Associate Professor, Kobe Pharmaceutical University
October 2002 Professor, Kobe Pharmaceutical University
March 2007 Professor/Director of Hospital Pharmacy, Kobe University School of Medicine
April 2017 Professor Emeritus of Kobe University

Awards

November 2015 Association Achievement Award of the Japanese Society of Pharmaceutical Health Care and Sciences
June 20017 Hospital Pharmaceutical Award of the Japanese Society of Hospital Pharmacists

Aiko Osawa

National Center for Geriatrics and Gerontology, Japan

Rehabilitation for People with Dementia and Their Family to Maintain a Safe and Calm Life

Abstract:

Rehabilitation is one of the best methods to support the daily and social lives of disabled people. Rehabilitation treatment is often focused on physical dysfunction, but cognitive impairment also needs to be treated. In dementia, activities are reduced in addition to cognitive dysfunction, resulting in various daily living problems. If the activity of a person with dementia declines and the person becomes shut in the house, all of the problems associated with dementia will be addressed only by the family, leading to social isolation. If this situation persists, physical, mental and economic collapse of caregivers may lead to violence toward and neglect of people with dementia. In order to overcome this situation, we are carrying out outpatient rehabilitation for people with dementia living at home and their families. To enable people with dementia to live safely and calmly at home, it is essential for their families to understand and cooperate with dementia. In this presentation, I will explain the assessment and treatment of people with dementia and their families to prevent social isolation, and outline the one-year course.

Keywords:

rehabilitation, family, social isolation

Speaker Information:

Aiko Osawa, M.D., Ph.D. is Director of Cognitive and Behavioral Science (2014-), and Director of the Department of Rehabilitation Medicine, National Center for Geriatrics and Gerontology, Obu, Japan (2017-). She received a Ph.D. from Saitama Medical University (2010, Japan). Dr. Osawa's current work includes cerebral stroke rehabilitation, especially cognitive dysfunctions and swallowing disorders. She also addresses the rehabilitation of patients with brain injury and dementia. She has published various papers in peer-reviewed journals.

Peter Gausmann

GRB Gesellschaft für Risiko-Beratung mbH, Detmold, Germany

Patient-Safety Malpractice Claims of Elderly Patients in Connection with in and Outpatient Care and Recommended Prevention Measures

Abstract:

We know from systematic reviews and analyses of loss events in connection with in and outpatient care that certain care areas are characterized by risks, which can be compensated by appropriate prevention measures. On international level, obstetrics, traumatology and anesthesiology for example, are classified as high-risk medical disciplines. A variety of technically assisted safety measures has been implemented for these areas in recent years, while not as much research exists for the risk management concerning the treatment of elderly patients as equal focus has not been given to its systematic prevention. The evaluation of a comprehensive German medical malpractice database showed that patients of a higher age become more often victims of medical malpractice, whereas claims payments decrease with age. Several factors account for this trend. The identification of causes and qualitative assessment of loss events are of vital importance for developing prevention measures. Based on the above-mentioned database, the following areas of prevention are relevant:

- Prevention of falls
- Prevention of pressure-induced ulcers
- Medication therapy safety, including in particular the prevention of polypharmacy
- Supply of orientational aids for patients with dementia-type illnesses
- Prevention of diagnostic errors in case of multimorbidity
- Monitoring elderly patients during preoperative processes.

Due to frequently occurring multimorbidity, senior patients are a special risk group in the complex and heavily dissected healthcare provision. In addition to therapists, also relatives play an important role as safety agents in the risk management of old-age patients. The therapeutic team must actively support this function.

Keywords:

Claims Analyses (Claims Assessment), Risk Management Measures, High-Risk Medical Disciplines, Prevention Measures

Speaker Information:

Dr. Peter Gausmann
Managing Director of GRB Gesellschaft für Risiko-Beratung mbH, Detmold (Germany)
Honorary Professor of the Danube University Krems
Lecturer at the College in Osnabrueck (Germany), Medical Faculty of the University of Heidelberg (Germany)
Consultant, Author and Lecturer on the topics of patient safety and clinical risk management
Member of the board of the platform Patient Safety in Austria
Member of the German-Chinese Society of Medicine
Member of the scientific advisory board of the research project GIO- Gestaltungskompetenz als Innovator für hochzuverlässige Organisationen im Gesundheitswesen (English: design competence as an innovator for highly reliable organizations in healthcare) (University of Osnabrueck)

Andrew Carson-Stevens

Cardiff University, U.K.

Sources of Unsafe Primary Care for Older Adults: Lessons from a National Patient Safety Reporting and Learning System

Abstract:

The safety of primary care is an emerging global priority for healthcare, catalysed by the leadership of the World Health Organization's Safer Primary Care Expert Group. This is mirrored in UK policy, where there is also recognition that vulnerable groups, like older adults, are a priority. Given this global interest, and the complexity of delivering healthcare to an ageing population, it is important to create a better understanding of the healthcare-associated harm experienced by older adults. Many health systems have established, or are in the process of launching, patient safety incident reporting systems. Such systems are predicated on incident reports providing an important lens for understanding unsafe care, in terms of what happened and perceived causes.

The Patient Safety (PISA) Research Group at Cardiff University have developed a mixed-methods process for generating learning from patient safety incidents occurring in primary care. Using an analysis of incident reports describing patient safety incidents involving older adults in England and Wales, I will: explore the practicalities of analysing incident reports to generate hypotheses (change concepts) and how these can be used as the basis for quality improvement projects; outline the key steps for primary care teams to start identifying, reporting, and investigating incidents, as well as involving patients and families in the learning process; and, present the ongoing challenges for maximising the utility of incident reports as informants of data-driven quality improvement.

Keywords:

patient safety, incident reporting, quality improvement

Speaker Information:

Andrew Carson-Stevens MBBCh PhD HonMFPH is a primary care doctor, the Patient Safety Research Lead at the Primary and Emergency Care Research Centre in Wales, and the founding leader of the Primary Care Patient Safety (PISA) Research Group at Cardiff University. The PISA Group has internationally recognised expertise in generating learning from patient safety incidents. From 2012-2016, Andrew was the UK and Ireland Faculty Lead for the IHI Open School at the Institute for Healthcare Improvement. In 2016, he was Clinical Lead for Quality Improvement and Patient Safety at the UK Royal College of General Practitioners (RCGP) and developed the RCGP Guide 'Reporting and learning from patient safety incidents in general practice'. Andrew is a Visiting Chair in the Department of Family Practice, University of British Columbia, Vancouver, Canada and Honorary Professor at the Australian Institute of Health Innovation, Macquarie University, Sydney, Australia.

Panel Discussion 3

Patient Safety Needs for Achieving Universal Health Coverage in Low- and Middle-Income Countries (LMICs)

Chair: Neelam Dhingra-Kumar

World Health Organization

Chair Information:

Dr Neelam Dhingra-Kumar is Coordinator for Patient Safety and Risk Management Unit, Service Delivery and Safety Department at the World Health Organization headquarters in Geneva, Switzerland. Dr Dhingra leads WHO's efforts at providing strategic leadership and policy advice in patient safety and risk management, and coordinates WHO's work for improving patient safety and managing risks in health care, including global patient safety challenge on medication safety; patient safety leadership; patient safety culture; education and training; patient safety standards, assessments, research and measurement; global patient safety networks and partnerships; safety and quality tools and checklists; reporting and learning systems; patient and family engagement including patients for patient safety; safer primary care; Safe Childbirth Checklist; Surgical Safety Checklist, standardizing care processes; and patient safety solutions. After joining WHO in 2000, Dr Dhingra provided strategic leadership and facilitated multi-country support for strengthening the delivery and safety of transfusion and laboratory services. Since 2014, Dr Dhingra has taken over the role of coordinating WHO global efforts in the areas of patient safety, quality and risk management. Prior to joining WHO, Dr Dhingra served as a faculty in a large, tertiary care university teaching hospital in New Delhi, India for 14 years, also coordinating transfusion and laboratory services. She obtained her medical graduation and post-graduation qualifications from New Delhi and fellowships in the United Kingdom as a haematologist, laboratory and transfusion medicine expert. Dr Dhingra's areas of expertise are policy and strategy formulation, priority setting, safety and quality of health services; vigilance, reporting and learning systems; establishing networks; quality and risk management systems; patient, family and community engagement; and assessments, monitoring, evaluation and operational research.

Chair: Jeremy HM Veillard

World Bank Group

Chair Information:

Program Manager, Primary Health Care Performance Initiative, The World Bank Group

Jeremy Veillard is a health sector leader with extensive experience in partnerships and in leading transformational change. He has extensive experience in partnerships in the health sector at hospital, provincial, Pan-Canadian and international levels. Jeremy is a hospital administrator by background with a PhD in health systems research and experience leading transformation at the Ontario Ministry of Health and Long-Term Care, internationally at the World Bank and the World Health Organization, at pan-Canadian level in Canada and at hospital level in France. He has worked in over a dozen countries and is fluent in English, French and Spanish.

Since June of 2015 Jeremy has applied his experience at The World Bank Group as the Program Manager, PHCPI & Strategic Policy Adviser to the Senior Director. In this role, he leads the Primary Health Care Performance Initiative (PHCPI) for the Bank, a presidential initiative involving the Bill and Melinda Gates Foundation and the World Health Organization. It is focused on accelerating performance improvement in the delivery of primary healthcare in low and middle-income countries.

Previous to The World Bank, Jeremy was the Vice-President, Research and Analysis with the Canadian Institute for Health Information. At CIHI he led all aspects of research and analysis with a staff of 150 people. He worked closely with provincial and federal governments, regional health authorities and health care providers on performance and health system transformation issues. Jeremy has a deep understanding of federal, provincial and territorial dynamics and knowledge of the key Canadian health sector participants in the areas of policy development. Focused on results, he is experienced in applying data and evidence to drive change in policy and service delivery.

Priyadarshani Galappatthy

Faculty of Medicine, University of Colombo, Sri Lanka

Addressing the Challenge of Medication Safety: Experiences from Sri Lanka

Abstract:

A Systematic review of published studies in Sri Lanka related to medication safety coupled with the personal experience of systems operating in the country identified the major challenges for medication safety and the ways to address these through a national action plan developed on medication safety. The main challenges are poorly functioning drug and therapeutics committees, inadequate safety culture, low medication incident reporting rates, high prevalence of irrational prescribing with non-adherence to clinical guidelines, lack of clinical pharmacist services, medicines dispensed by unqualified personnel in the private sector and dispensing medicines without proper labeling and sometimes without prescriptions. Some key issues are poor legibility of prescriptions (50 - 65%), low generic prescribing in private sector (36%), poly-pharmacy (83% among hospitalized elderly patients), using error prone abbreviations (67%), potential drug interactions in prescriptions (50%), dispensing unlabeled medicines (98%) very short dispensing times, registration and availability of large number of different brands (eg. atorvastatin 143 products registered), self medication (35%) and poor medication literacy (46%) despite high overall literacy (94%).

A short and long-term plan for medication safety through a national action plan was developed targeting the four strands identified by the WHO Global patient safety challenge on medication safety. Proposed actions include improving medication management systems, introducing a medication incident reporting system through the Directorate of Healthcare Quality and Safety, incorporating components of medication safety curriculum to all medical faculties, multi-professional training on medication safety and improving medication literacy among patients through a variety of means with involvement of all stakeholders.

Keywords:

Medication safety, national action plan, Global patient safety challenge, incident reporting, prescription errors, medication literacy, medication safety curriculum

Speaker Information:

Priyadarshani Galappatthy MBBS, MD, DipMedTox, FCCP, FRCP(Lond) is a Consultant Physician and Professor in Pharmacology in the Department of Pharmacology, Faculty of Medicine, University of Colombo, Sri Lanka. She graduated and obtained MD with Board certification as a specialist in General Medicine from the University of Colombo. She had training in Clinical Pharmacology and General Medicine in the UK and obtained MRCP (UK) from Royal College of Physician of London and Diploma in Medical Toxicology from University of Wales College of Medicine, Cardiff. She is a Fellow of Ceylon College of Physicians (FCCP) and a Fellow of Royal College of Physician of London (FRCP).

She has given leadership to several researches and projects related to medication safety in Sri Lanka and developed the national action plan on medication safety. Projects commenced include initiating a medication incident reporting system, development of a medication safety practice package and indicators of medication safety for the local hospitals as postgraduate projects. She conducts regular training programs and symposia on medication safety for all categories of healthcare professionals and educates the public on medication safety.

Sir Liam Donaldson

UK and WHO Patient Safety Envoy

Medication Without Harm - One year on WHO 3rd Global Patient Safety Challenge and Patient Stories - Provoking Debate to Generate Change

Speaker Information (Video Presentation):

Professor Sir Liam Donaldson is recognised as an international champion of public health and patient safety. He was the foundation chair of the World Health Organisation's World Alliance for Patient Safety, launched in 2004. He is a past vice-chairman of the World Health Organisation Executive Board. He is now the World Health Organisation's Envoy for Patient Safety, Chairman of the Independent Monitoring for the Global Polio Eradication Programme, as well as Chairman of the Transition Monitoring Board of this Programme. In the UK, he is Professor of Public Health at the London School of Hygiene and Tropical Medicine, Honorary Distinguished Professor at Cardiff University, Associate Fellow in the Centre on Global Health Security at Chatham House, and Chancellor of Newcastle University. Prior to this appointment Sir Liam was the 15th Chief Medical Officer for England, and the United Kingdom's Chief Medical Adviser, from 1998-2010. During his time in this historic post (established in 1855) he held critical responsibilities across the whole field of public health and health care. As the United Kingdom's chief adviser on health issues, he advised the Secretary of State for Health, the Prime Minister and other government ministers. He has produced landmark reports which have set health policy and legislation in fields such as stem cell research, clinical governance, quality and safety of health care, infectious disease control, patient empowerment, poor clinical performance, smoke free public places.

Piyawan Limpanyalert

The Healthcare Accreditation Institute (Public Organization), Thailand

Patient Safety in Primary Care Settings - Experiences from Thailand

Abstract:

Introduction: Unsafe primary care is particularly concerned in lower- and middle-income countries (LMICs), where limited resources lead to risks of medical errors. Failure to deliver safe primary care hinders an ensured path of LMICs to achieve Universal Health Coverage (UHC). We report how public policies have been developed to promote patient safety in primary care under Thai UHC.

Methods: A qualitative study was conducted. Data were collected from documentary reviews and in-depth interviews with policymakers and stakeholders of Thailand's primary care systems. Qualitative data were analyzed by thematic content analysis.

Results: Public policies to promote safety in primary care of Thailand was developed through extensive consultations over time since the UHC was implemented in 2002. In early years, participants believed primary care were utilized to simply increase healthcare accessibilities for the newly insured populations. But its public perception of lower quality resulted in patients bypassing primary care to hospitals. In response, national policies aiming to increase primary care's quality and safety were launched, namely "Family Care Team", "Primary Care Cluster" and "District Health Systems Accreditation Program" addressing integration between primary care and community hospitals, "2PSafety" promoting engagement of patients and providers, and national frameworks of "Rational Drug Use" and "Social Media Guidelines for Healthcare Practitioners". Existing challenges are risks management of human factors, administrative errors, diagnostic errors, medication errors, and transitions of care. The central database of patient safety incident reports of the "National Reporting and Learning System" (NRLS) should also be expanded from hospitals to primary care.

Conclusions: Despite implementation challenges that must be overcome, the Thai experiences demonstrate that patient safety can be improved in primary care settings of LMICs. Continuing engagement of stakeholders in different settings should increase the likelihood that such policies are scaled up nationwide. These lessons learned have implications for healthcare reforms in LMICs.

Keywords:

patient safety, primary care

Speaker Information:

Dr. Piyawan Limpanyalert is the Deputy CEO of the Healthcare Accreaditation Institutes (Public Organization), who is the obstetric and gynecologist doctor and has experinces in hospital management and quality improvement for > 15 years. She is also an expert in organizing and establishing Communities of Practice for healthcare system by faciliating stakeholders to share knowledge and experiences and to identify good practices. In collaboration with WHO, she has developed an umbrella of Engagement for Patient Safety, which includes 3 programs: Patient Safety Education, Patients for Patient Safety, and Safe Hospital. Through these programs, key stakeholders are engaged as partners in a nation-wide movement to improve patient safety using concept known as the Triangle that Moves the Mountain. This concept aims to the forefront of Thai health services by guiding and facilitating three primary modes; knowledge, social mobilization and health policy. Sustainable and lasting outcomes, will only be possible through the engagement of all healthcare stakeholders included patients and families to be active partner in such movement.

Neelam Dhingra-Kumar

World Health Organization

Safer Primary Care: an Imperative for Universal Health Coverage

Abstract:

Primary care services are at the heart of health care in many countries, and provide an entry point into the health system. Unsafe primary care may increase morbidity and preventable mortality. Thus, improving safety in primary care is essential when striving to ensure universal health coverage and the sustainability of health care. Patient safety has typically focussed on care delivered within the hospital setting. However, most care globally is delivered in primary care. Unsafe primary care can cause avoidable illness and injury, leading to unnecessary hospitalisations, and in some cases disability and even death. Areas of focus to achieve safer primary care:

Patients: People using health services should have an essential role as co-producers of their health. By tapping into this resource we could significantly improve patient safety in primary care.

Health Workforce: Education and training is required in order to increase the recognition of the importance of improving safety, and take a systematic approach to education helping health care professionals develop skills to identify and reduce harm.

Tools and Technology: Electronic tools can help address these challenges, and their implementation, if not well-designed, can have unintended adverse consequences.

Care processes: Administrative, diagnostic and medication errors all occur in primary care. Also, multi-morbidity increases the risk of patient safety issues due to for example, polypharmacy and demanding self-management regimes. Furthermore, patients are more vulnerable when they move across healthcare systems as clinical information may be lost and require coordination.

Accessible and safe primary care is essential to achieving universal health coverage and to supporting the UN Sustainable Development Goals.

Keywords:

Patient Safety, Safety of Primary Care, Safer Primary Care, Universal Health Coverage

Speaker Information:

Dr Neelam Dhingra-Kumar is Coordinator for Patient Safety and Risk Management Unit, Service Delivery and Safety Department at the World Health Organization headquarters in Geneva, Switzerland. Dr Dhingra leads WHO's efforts at providing strategic leadership and policy advice in patient safety and risk management, and coordinates WHO's work for improving patient safety and managing risks in health care, including global patient safety challenge on medication safety; patient safety leadership; patient safety culture; education and training; patient safety standards, assessments, research and measurement; global patient safety networks and partnerships; safety and quality tools and checklists; reporting and learning systems; patient and family engagement including patients for patient safety; safer primary care; Safe Childbirth Checklist; Surgical Safety Checklist, standardizing care processes; and patient safety solutions. After joining WHO in 2000, Dr Dhingra provided strategic leadership and facilitated multi-country support for strengthening the delivery and safety of transfusion and laboratory services. Since 2014, Dr Dhingra has taken over the role of coordinating WHO global efforts in the areas of patient safety, quality and risk management. Prior to joining WHO, Dr Dhingra served as a faculty in a large, tertiary care university teaching hospital in New Delhi, India for 14 years, also coordinating transfusion and laboratory services. She obtained her medical graduation and post-graduation qualifications from New Delhi and fellowships in the United Kingdom as a haematologist, laboratory and transfusion medicine expert. Dr Dhingra's areas of expertise are policy and strategy formulation, priority setting, safety and quality of health services; vigilance, reporting and learning systems; establishing networks; quality and risk management systems; patient, family and community engagement; and assessments, monitoring, evaluation and operational research.

Robinah K. Kaitiritimba

Uganda National Health Consumers' Organization (UNHCO), Uganda

Leveraging Health System Resources for Patient Safety

Abstract:

Globally, there's overwhelming evidence to demonstrate that high proportions of ill-health can be prevented (WHO, 2017). The major challenge is that the healthcare system has been oriented and inclined to clinical care, giving limited attention to the Social Determinants of Health and the role of patients - a missed opportunity.The Sustainable Development Goal 3.8 presents a paradigm shift from clinical care to overall well-being for patient safety and universal health coverage. Through effective and efficient use of health system resources, prevention of system failures, violations, errors, injuries, accidents and infections can be minimized. These resources may include professional Human Resources for Health, the community, patients, institutions and finances.

Organizing and ensuring that the available resources are optimally utilized is a leadership function and calls for harmonizing the resources and building motivated professional teams that will deliver patient safety and well-being.

There is also urgent need to invest and harness resources from the different sectors to build leadership capacity at all levels and professions for patient safety. This will strengthen the integration and collaborative efforts by the different sectors to mobilize resources for achieving patient safety.

Keywords:

Leadership, Capacity, Patient safety, health- system, resources, violations, errors

Speaker Information:

Executive Director of Uganda National Health Consumers' Organization, seasoned expert on the right to health, authority on the Rights Based Approach (RBA) and represents Civil Society on the highest policy making organ at the Ministry of Health - the Health Policy Advisory Committee. She has worked in the health sector for over 15 years. As a Patient Safety Champion for AFRO- region of World Health Organisation Patient Safety Programme, she has served on expert Panels including Childhood Obesity, Injection Safety, among others.

She is a member of the Institutional Review Board of Makerere University School of Public Health and Uganda National Council for Science and Technology -Bio-Safety Committee. Robinah has presented papers and done research on various topics at national and international levels. Her greatest contribution is empowerment for improving healthcare user participation and health outcomes for vulnerable communities and spearheading the development and adoption of the Patients' Charter for Uganda.

Criselda G. Abesamis

Department of Health, Philippines

Improving Efficiency and Saving Cost: The Philippine Experience

Abstract:

The country's journey towards achieving UHC has been anchored in its Health Sector Reform Agenda (HSRA) which started more than a decade ago. The current administration further builds upon the successes in the pursuit of UHC through the "FOURmula ONE for Health Plus" (F1 Plus), which boosts the health sector's reform strategies on financing, service delivery, regulations, governance, and performance accountability.

In sync with the UHC framework, patient safety is further strengthened with efficiency and cost controls in health facilities such as the drug formulary that helps regulate quality and safe medication, and PhilHealth's rules that ensure quality and appropriate health services. The Philippine Government is also currently in the process of legislating UHC with provisions in instituting patient safety as part of the goal of improving the quality of services in health facilities.

Technical stewardship of the Patient Safety Program continuously improves evidence-based policies and programs; with a campaign to push for a Culture of Safety and Patients First, evidence is emerging supporting operational and cost efficiency of patient safety interventions. The Program's development horizon includes institutionalization of occupational safety and health in healthcare facilities, adverse events reporting, capacity building for implementation of standards of care for older persons, and the development of standards and guidelines toward the creation of Safe and Green Hospitals, the SMART Hospital, for climate resilience.

Keywords:

Philippine Patient Safety Program, Department of Health

Speaker Information:

Dr. Criselda G. Abesamis is a Career Executive Service Officer in the Philippine Government. She has been in government service, particularly in the Department (Ministry) of Health for the past 35 years and rose through the ranks. She is the incumbent Bureau Director IV, Health Facilities Development Bureau, Department of Health, Manila, Philippines.

The Patient Safety Program is under this Bureau, together with complementary health facility-based programs like the Continuing Quality Improvement (CQI) Program, Infection Prevention and Control Program, Integrated Hospital Operations and Management Program, Health Care Waste Management Program, Green and Safe Hospitals and Health Facilities for Climate resiliency, National Voluntary Blood Services Program, National Laboratory Networks and the overarching national plan for the development of health care facilities in the country, the Philippine Health Facility Development Plan (2017-2022).

Panel Discussion 4

Information and Communication Technology (ICT) in Patient Safety

Chair: Hiroshi Takeda

Graduate School of Health Care Sciences, Jikei Institute, Japan

Chair Information:

Currently Professor Emeritus at Osaka University and the President at Graduate School of Health Care Sciences, Jikei Institute that has the first and only one master course for patient safety management in Japan. He has engaged in medical informatics as professor (1998-2010) at Osaka University, where his team has developed a totally paperless hospital information system in 2010. He has also worked in patient safety as the Director of Healthcare Quality Management of Osaka University Hospital (2001-2008) and the President of Healthcare Quality Management Association of Japanese National University Hospitals (2002-2008). His career in the International Medical Informatics Association (IMIA) is SPC co-chair of MEDINFO2001, Vice President (2004-2010) ,IMIA Liaison to IFIP (2007-) WG chair (Patient Safety Informatics). In the government, he was Senior Specialist for Scientific Affairs, the Ministry of Education, Science and Culture of Japan (1983-1985).

Chair: Edward Kelley

Director, Service Delivery and Safety, WHO-HQ

Chair Information:

Dr Edward Kelley is Director of the Department of Service Delivery and Safety at the World Health Organization. In this role, he leads WHO's efforts to strengthen the safety, quality and people-centredness of health services globally towards achieving universal health coverage. He manages WHO's work in a wide range of programmes, including patient safety, health services integration and regulation, quality systems and resilience, traditional, complementary and integrative medicine, emergency and essential surgery, transplantation, hospital management, blood and transfusion safety, as well as WHO-wide initiatives of primary care, quality measurement, palliative care, digital health and genomics. Dr Kelley also led the Infection Prevention and Safety and the Health Systems Recovery teams during WHO's Ebola response effort.

Formerly, Dr Kelley coordinated both strategic management and external relations and business development for the World Alliance for Patient Safety, with responsibility for administration of the department and teams working in health care-associated infection, technology, capacity-building, reporting and learning and patient and family empowerment. Following the two very successful WHO Global Patient Safety Challenges on improving hand hygiene ("Clean Care is Safer Care") and surgical safety ("Safe Surgery Saves Lives"), Dr Kelley is currently leading a new WHO Challenge to improve medication safety ("Medication without Harm"), all of which have had significant impact on raising awareness of and improving patient safety across the world.

Prior to joining WHO, Dr Kelley was Director of the first United States National Healthcare Reports for the US Department of Health and Human Services in the Agency for Healthcare Research and Quality (AHRQ). Dr Kelley also directed the 28-country Health Care Quality Improvement (HCQI) Project for the Organisation for Economic Co-operation and Development (OECD). Before this, Dr Kelley served as Senior Researcher and Quality Assurance Advisor in the Operations Research Division for the USAID-sponsored Quality Assurance Project (QAP) and Partnerships for Health Reform Project Plus (PHRPlus). In these capacities, he worked for ten years in West and North Africa and also Latin America, directing research on the management of childhood illness in Niger.

Dr Kelley's other experience includes being a Manager for the Advisory Board Company, a large health care consulting firm based in Washington, DC. And while at AHRQ, Dr Kelley also served as an Associate Professor at Johns Hopkins School of Public Health, where he was involved in courses and research in health systems management and health systems statistics. Dr Kelley's research and project work has produced numerous publications in the areas of health systems performance measurement and improvement, value for money in health care, cost and quality interactions and the clinical areas of paediatric infectious disease, respiratory illness, cardiac care and cancer survival. Dr Kelley is also a Commission member of The Lancet Global Commission on High Quality Health Systems in the SDG Era and other major global initiatives for global health security, quality improvement, and health system strengthening.

Dr Kelley's research primarily focuses on patient safety, quality and the organization of health services, metrics and measurement in health services, as well as health systems improvement approaches and policies.

Donald M. Berwick

Institute for Healthcare Improvement, U.S.A.

Utilization of Big Data for the Measurement of Safety

Abstract:

Modern health care information technology, especially including the maturation of electronic health records, is creating new opportunities to monitor patient safety and risks in real time, with rapid reporting, and at far lower cost than previously. For example, an important patient safety measurement method is the "IHI Global Trigger Tool" (GTT), developed in the past decade by faculty at the Institute for Healthcare Improvement (IHI), which has been shown in multiple studies to be a highly sensitive way to detect patient harm. As initially created, the Global Trigger Tool requires intensive and costly record reviews and the time of experts. It will soon be feasible to automate the GTT in an electronic medical record environment, offering a rapid and inexpensive metric of system safety.

However, measurement, alone, will not assure improvement. Whether or not the use of large data sets to assess safety will actually contribute to safety improvements depends far more on managerial and cultural beliefs and behaviors than on the technology, itself. If rapid assessment of harm and hazards is used primarily for external surveillance, external accountability, rewards, punishments, league-tables, and blame, then one would predict, not safety improvement, but costly forms of fear, self-justification, and data manipulation among the workforce. On the other hand, if such information is made available and used locally for learning, exchange, growth, and development, valuing local curiosity and avoiding blame, then favorable dynamics can emerge to support the continual improvement of patient safety.

Keywords:

Electronic medical records, IHI Global Trigger Tool, measurement of safety, culture of safety

Speaker Information:

Donald M. Berwick, MD, MPP, FRCP, KBE, is President Emeritus and Senior Fellow at the Institute for Healthcare Improvement (IHI), an organization that Dr. Berwick co-founded and led as President and CEO for 18 years. He is one of the nation's leading authorities on health care quality and improvement. In July, 2010, President Obama appointed Dr. Berwick to the position of Administrator of the Centers for Medicare and Medicaid Services (CMS), which he held until December, 2011. A pediatrician by background, Dr. Berwick has served as Clinical Professor of Pediatrics and Health Care Policy at the Harvard Medical School, Professor of Health Policy and Management at the Harvard School of Public Health, and as a member of the staffs of Boston's Children's Hospital Medical Center, Massachusetts General Hospital, and the Brigham and Women's Hospital. He has also served as vice chair of the U.S. Preventive Services Task Force, the first "Independent Member" of the Board of Trustees of the American Hospital Association, and chair of the National Advisory Council of the Agency for Healthcare Research and Quality. He is an elected member of the American Philosophical Society and of the National Academy of Medicine (formerly the Institute of Medicine). Dr. Berwick served two terms on the IOM's governing Council and was a member of the IOM's Global Health Board. He served on President Clinton's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry. He is a recipient of numerous awards, including the 1999 Joint Commission's Ernest Amory Codman Award, the 2002 American Hospital Association's Award of Honor, the 2006 John M. Eisenberg Patient Safety and Quality Award for Individual Achievement from the National Quality Forum and the Joint Commission on Accreditation of Healthcare Organizations, the 2007 William B. Graham Prize for Health Services Research, the 2007 Heinz Award for Public Policy from the Heinz Family Foundation, the 2012 Gustav O. Lienhard Award from the IOM, and the 2013 Nathan Davis Award from the American Medical Association. In 2005, he was appointed "Honorary Knight Commander of the British Empire" by Queen Elizabeth II, the highest honor awarded by the UK to non-British subjects, in recognition of his work with the British National Health Service. Dr. Berwick is the author or co-author of over 160 scientific articles and six books. He also serves now as Lecturer in the Department of Health Care Policy at Harvard Medical School.

Johanna Westbrook

Centre for Health Systems and Safety Research, Macquarie University, Director, Australia

Evaluating the Effects of Health Information Technology

Abstract:

The landscape of health care organisations worldwide is changing with the rapid and widespread investment in, and adoption of, information and communication technologies (ICT). Information systems are often promoted as making work safer and more efficient. As the demands on health care resources continue there is an increasing impetus to understand, and to be able to demonstrate, the benefits and challenges ICT provides to the many stakeholders in the health system.

This presentation will report on several multi-method studies which have sought to quantify the effects of electronic health record systems in hospitals on errors, test ordering patterns, health professional work patterns and costs. The research has also investigated unexpected consequences of electronic systems and the introduction of new types of errors. The results have implications for organisations implementing health IT in terms of designing monitoring mechanisms which allow systems to be continually improved, and to be able to quantify how investments in health IT can translate into measurable improvements for patients and health professionals.

Keywords:

Electronic medication management, medication errors, health care evaluation, IT safety, electronic decision support systems, clinical workflow

Speaker Information:

Professor Johanna Westbrook, is Director of the Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, Macquarie University. She is internationally recognised for her research evaluating the effects of information and communication technology (ICT) in health care.

Johanna has led important research in the development and application of approaches to evaluate ICT, including new tools and methods which have been adopted internationally. She has contributed to theoretical models regarding the design of complex multi-method ICT evaluations. Her research has led to significant advances in our understanding of how clinical information systems deliver (or fail to deliver) expected benefits and supported translation of this evidence into policy, practice, and IT system changes. Johanna has over 390 publications and been awarded > $45M in research grants.

Johanna is an elected International Fellow of the American College of Medical Informatics, Fellow of the Australasian College of Health Informatics, and an Associate Editor of the Journal of the American Medical Informatics Association. In 2014 she was named Australian ICT professional of the year by the Australian Information Industry Association. In 2016 she was appointed by the Federal Minister for Health to the Board of the Australian Digital Health Agency. She is Chair of the Deeble Institute Advisory Board, Australian Healthcare and Hospitals Association. The Institute has a major focus on driving evidence-based health policy.

Hideo Kusuoka

National Hospital Organization, Japan

Incidents in Patient Safety caused by Hospital Information System

Abstract:

Hospital Information System (HIS) including Ordering System and Electronic Medical Record promotes patient safety through the increase in transparency of medical process and the simultaneous handling of patient data among medical team. However, HIS also causes incidents in medical process due to bags in HIS, misuse of HIS, wrong management of HIS, and so on. The Japan Council for Quality Health Care (JQ) was established in 1995 to improve both quality and safety in health care. JQ's Hospital Accreditation has been officially approved by the International Society for Quality in Health Care. The Section of IT and Equipment in the Council for Patient Safety Promotion (PSP) of the accredited hospitals was set in 2003, and studied the incidents relating HIS until 2015. The Section collected incidents assumed to be caused by HIS from the member hospitals of PSP every year, analyzed them with HIS vendors, and categorized them based on three viewpoints, i.e., scene of trouble, origin of trouble, and system. The categorized cases were published in PSP Journal several times, and contributed to educate hospital staffs engaged in the management of HIS. The Section also presented "the Quality Index to evaluate patient safety relating with HIS" as the measure of good practice of HIS relating patient safety. The Section also presented the Check List arranged from the viewpoint of patient safety using in constructing HIS in a hospital. It is important to consider the role of HIS in patient safety.

Keywords:

Hospital Information System (HIS),
patient safety
Japan Council for Quality Health Care

Speaker Information:

Hideo Kusuoka, MD, PhD graduated from Osaka University Medical School in 1975, and received the Doctor of Engineering (1985) and PhD in Medical Sciences (1987) from Osaka University. He was appointed as Assistant Professor of Electrical Engineering in Osaka University, Assistant Professor of Medicine in the Johns Hopkins University, Associate Professor of Nuclear Medicine in Osaka University Medical School, and Director of Institute for Clinical Study, Vice Director, and General Director of Osaka National Hospital. He is currently the President of National Hospital Organization since 2016. He is also serving as the member of Art of Medicine Council, Social Security Council, and Health Science Council of Ministry of Health, Welfare and Labor in Japan, and Science Council of Japan. His specialty is clinical cardiology, medical informatics, regulatory science, and medical engineering.

Sanjeeva Kumar

Additional Secretary (Health), Ministry of Health & Family Welfare, India

Information & Communication Technology (ICT) & Patient Safety: Indian Experience

Abstract:

Plurality of the Health systems and their ownership in the country make designing an inclusive patient safety policy framework and its implementation a challenging task.

National Patient Safety Implementation Framework is on verge of finalisation. Key features of the framework are operationalisation of Patient Safety Steering Committees, defining minimum standards and indicators for the patient safety, IT enabled reporting mechanism, strengthening of infection control & waste management practices and promoting research.

For improving quality of the services, the country has ISQua accredited quality standards for public health facilities. Various dimensions of patient safety have been built into the system and are getting measured.

Minimum standards for Healthcare facilities have also been defined under the Clinical Establishment Act also.

The country has also launched Pharmacovigilance Program (PvPI) and Adverse Drug Reactions (ADRs) are being reported regularly. The programme works in collaboration with the global ADR monitoring centre (WHO-UMC).

The country has been integrating IT platform for improving delivery of Health services and improving patient safety. Few such examples are National Health Portal, National Identification Number of Health Facilities, Integrated Health Information Platform, Electronic Health Record, Telemedicine & Tele-radiology, Mera-Aspataal patient feedback, CVDMS, etc.

'Gunak' an Android based app. has been developed for Quality Assessment of Health Facilities.

Discussions & consultations with stakeholders are in progress on creating National e- Health Authority.

Presently issues pertaining to Patient safety are reported through different electronic platform. After operationalisation of National Patient Safety Implementation Framework, there would be unified reporting.

Speaker Information:

Mr. Sanjeeva Kumar belongs to Indian Administrative Service and is currently posted as Additional Secretary & DG (NACO & RNTCP) in the Ministry of Health & Family Welfare. Joining the service in 1986, he has a career spanning more than 30 years in the Central Government and the States. He started his career as a Sub Divisional Officer and subsequently held the post of Deputy Commissioner in 3 districts of Assam for more than 7 years. He has served in Ministries of Finance and Defence and also as Chief Vigilance Officer of ONGC at the Centre. Mr. Kumar has rich and varied experience of working in different Departments such as Home, Finance, Labour, Environment & Forests, Health & Family Welfare and Irrigation in the State Governments of Assam and Meghalaya in leadership position.

He is a post-graduate in Development Studies from the Institute of Social Studies (ISS), Erasmus University, The Hague, Netherlands and also an alumnus of Jawaharlal Nehru University and Delhi University.

Kazue Nakajima

Osaka University Hospital, Japan

Nurturing Resilience in Complex Adaptive Systems for Patient Safety and Quality Improvement with the Support of Information and Communication Technology

Abstract:

The conventional approach to patient safety (Safety-I) aims to analyze and prevent failures. A new approach based on resilience engineering (Safety-II) seeks to synthesize resilient health care systems in which things go well in changing environments with multiple perturbations and constraints.

Biological systems function resiliently, exhibiting adaptive, autonomous, and decentralized behavior in constantly changing environments. When dynamic structures of a system (process) change through non-linear interactions among its parts, a new function emerges allowing the whole system to adapt. Thus, interactions and interconnectivity among parts or subsystems are key to resilience.

Health care systems must sustain their functions in a VUCA (volatile, uncertain, complex, and ambiguous) world. The main function of these systems is to support dynamic and diverse patient journeys while providing quality and safety care. When the "three Cs" are carefully implemented, information and communication technology nurtures resilience overall by changing interactions and interconnectivity within health care systems.

The first C is common databases in which electronic patient records, operational data, videos, incident reports, and other data are integrated to enable just-in-time information delivery for patient care, as well as data analytics for proactive safety and quality management. The second C is common platforms, which are designed to facilitate autonomous and decentralized interactions (e.g., peer-to-peer networks connecting patients with the same illness). The third C is common language, which is used to integrate community care comprising different care settings. In summary, a synthetic approach to quality and safety in complex adaptive systems should explored by looking at systems broadly.

Keywords:

patient safety, quality improvement, safety-I, safety-II, information and communication technology, resilience engineering, systems' resilience, complex adaptive system, dynamics, interactions, interconnectivity, non-linearity, autonomy, decentralization, synthesis

Speaker Information:

Kazue Nakajima, MD, MSc, PhD is Director and Professor of the Department of Clinical Quality Management, Osaka University Hospital, Japan. After becoming a pharmacist and then an internist, she studied health policy and management as a Fulbright scholar at the Harvard School of Public Health, completed an internship at the Harvard Risk Management Foundation, and then worked for 20 years on patient safety and quality improvement. Her department has served as secretariat for the Patient Safety Alliance of 45 national university hospitals and as organizer of annual patient safety seminars for all university hospitals in Japan. Dr. Nakajima has presented at national and international conferences in health care and other industries on more than 600 occasions. She has also educated medical, dental, pharmaceutical, and other healthcare students at different universities. She has been awarded competitive research grants and several prizes for safety-related activities, including a hospital-wide patient engagement program.

Panel Discussion 5

Economics on Patient Safety

Chair: Ingo Härtel

Federal Ministry of Health, Germany

Chair Information:

Dr. Ingo Härtel holds a doctorate in medicine from the Charité, Berlin and an MA in bioethics from the Kennedy Institute of Ethics, Georgetown University, Washington, DC. His current position is that of Deputy Head of the Division for 'Health Law, Patients' Rights, Patient Safety' at the German Federal Ministry of Health, where his work includes questions of patient safety, bioethics, biopolicy, genomics and genetics at national and international level. Prior to his current post, he worked for the office of the Enquete Commission "Law and Ethics in Modern Medicine" at the German Bundestag, where he drafted the Report to the Parliament on Stem Cell Research. He has gained professional experience in the fields of policy-making, medicine and science administration.

He is the Joint Chair of the Steering Committee for the Global Ministerial Summits on Patient Safety. Previously, he has served as the Secretary General of the Inter-Ministerial Working Group on Regulatory Affairs in Biomedicine and Bioethics and as delegate to the OECD's Working Party on Biotechnology. Currently, he is representing Germany in the Bioethics Committee of the Council of Europe (DH-BIO) and in the Intergovernmental Bioethics Committee (IGBC) of UNESCO.

Nicolaas Sieds Klazinga

Head of the Health Care Quality Indicators, Organisation for Economic Co-operation and Development (OECD)

Flying Blind

Abstract:

Ambulatory and primary constitute a major part of health care with around 8 billion encounters between patients and health care professionals in OECD countries alone. Despite its importance, little is known about the occurrence of adverse events and patient harm in these settings. Findings from a recent OECD report on the occurrence, burden, costs and economic impact of safety lapses in ambulatory/primary care will be presented, showing that as many as 20%-25% of the general population experience harm in developed and developing countries respectively and half of the disease burden related to patient harm stems from this setting. Related costs on additional tests and treatments are estimated to be around 2.5% of total health expenditure and estimated total costs, also including preventable hospital admissions in developed countries, suggest this can approach 3 % of GDP. Emphases is on diagnostic errors, medication failures and safety risks associated with administrative processes that are related to the fragmented nature of primary- and ambulatory care. Results of a survey amongst safety experts and policy makers on the "best strategies" to tackle patient safety in ambulatory/primary care settings will be presented. Overall recommendations focus on the active measurement and use of the findings on adverse events and patient harm in ambulatory/primary care settings. Active involvement of patients is essential. Measurement initiatives will only succeed when a learning culture and (political) leadership is present. Unless we provide better insight in safety in ambulatory/primary care we are flying blind on the long distance of continuous patient care delivery as provided in ambulatory and primary care.

Speaker Information:

Niek Klazinga is since 2006 the coordinator of the Health Care Quality Indicator program at the OECD in Paris. He combines this work with a professorship in Social Medicine at the Academic Medical Centre at the University of Amsterdam. Dr. Klazinga has been involved over the past 30 years in numerous health services research projects and policy debates on quality of care and published widely on the subject. Present commitments include a visiting professorship at the Corvinus University in Budapest and the University of Toronto, advisor to WHO/Euro, advisor to the Canadian Institute for Health Informatics and member of the board of trustees of the Isala Clinics (Zwolle, a large teaching hospital in The Netherlands) and Arkin (Amsterdam, one of the largest mental health care institutes in The Netherlands). Dr. Klazinga has (co)authored around 200 articles in peer-reviewed journals and to date completed the supervision of 36 PhD trajectories.

Chris A. Power

Canadian Patient Safety Institute

The Case for Investing in Patient Safety: The Canadian Experience

Abstract:

Interested in developing a monetary case for why governments and health care organizations should invest in patient safety, the Canadian Patient Safety Institute (CPSI) commissioned RiskAnalytica to conduct a Canadian analysis. The compelling results concluded that over the next 30 years in Canada, within acute and home care settings, there could be roughly 400,000 average annual cases of patient safety incidents (PSIs), costing approximately $6,800 per patient and generating an additional $2.75 billion (2017) in healthcare treatment costs per year. The PSIs considered and the costs incurred are all preventable. In terms of mortality, PSIs in total (acute/home care combined) rank third behind cancer and heart disease with just under 28,000 deaths across Canada (in 2013). This is equivalent to such events occurring in Canada every 1 minute and 18 seconds and a resulting death every 13 minutes and 14 seconds. In the acute care setting, infections will be the biggest driver of PSIs while in the home care setting, trauma (e.g. falls) will top the list. This presentation will provide the background, analysis and results of the commissioned work.

Keywords:

Patient Safety, patient safety incidents, scale, cost, benefits,impact

Speaker Information:

What began as a desire to help those in need 35 years ago has evolved into a mission to improve the quality of healthcare for all Canadians. Chris Power's journey in healthcare began at the bedside as a front-line nurse. Since then, she has grown into one of the preeminent healthcare executives in Canada. Her experiences, her success, and her values have led her to the position of CEO of the Canadian Patient Safety Institute.

Previously, Chris served for eight years as president and CEO of Capital Health, Nova Scotia. She holds significant governance roles including Chair of the Canadian Association for Health Services & Policy Research, Co-Chair of CHLNet and Board member of Colleges & Institutes of Canada.

Most recently Chris participated as a member of the federal advisory panel on healthcare innovation. Her love of family and gift of song keep her grounded in all that she does.

Summary of Expert Summit

Chair: Shunzo Koizumi

Shichijo Clinic, Kyoto, Japan

Chair Information:

Shunzo Koizumi, M.D., F.A.C.S., Professor Emeritus, Saga University is a Board Member of Japanese Society for Quality and Safety in Healthcare (JSQSH) and the Editor-in-Chief of Japanese Journal of Quality and Safety in Healthcare since 2005. Since 2015, he also chairs Working Group on Excessive Healthcare and "Choosing Wisely" Campaign of JSQSH. He is also the Executive Board Member of Japanese Coalition for Patient Safety since 2013.

After graduating from Kyoto University, Faculty of Medicine in 1971 and had worked at several hospitals in Japan as an internist and anesthesiologist, he joined residency programs in general surgery in Youngstown, Ohio, (first year) and Bridgeport, Connecticut (second through fifth years, St. Vincent's Medical Center, a Yale affiliated program), U.S.A.

Returning to Japan, he worked at Tenri Hospital in Nara for 13 years both as a general surgeon and co-director of residency program of that hospital.

In 1994, he was appointed as the Professor and Chairman of the Department of General Medicine, Saga University Hospital. He also served as an Associate Hospital Director (2002 - 2004) and then a Special Advisor to Hospital Director (2004 - 2010).

Since 2011, he has been practicing primary care at Shichijo Clinic in Kyoto, Japan.

He writes and translates textbooks on healthcare, clinical diagnostics and medical education. He is a Fellow of American College of Surgeons, a member of Society of General Internal Medicine (SGIM) and an affiliate member of American College of Physicians, Senior Advisor to Japan Primary Care Association and an Honorary Member of Japan Society for Medical Education.

Evening Session

Japan's National Patient Safety System

Chair: Hirobumi Kawakita

Japan Council for Quality Health Care (JQ)

Chair Information:

Title:

Chairman & CEO	Kawakita Medical Foundation
	Kawakita General Hospital (October 1988~)
Chair	Japan Council for Quality Health Care (June 2016~)
Vice-Chairman and Chief Executive Director	
	Japan Council for Quality Health Care (July 1995~)
Chairman	Tokyo Metropolitan Hospital Association (April 1999~)
Lecturer	University of Tokyo, School of Medicine (October 1991~)
Lecturer	University of Kyoto , School of Medicine (October 2000~)
Lecturer	Keio University, School of Medicine (April 2005~)

Educational Background:

March 1977	MD Keio University, School of Medicine
August 1983	MBA University of Chicago, Graduate School of Business
March 1984	PhD in Pathology Keio University, School of Medicine

Business Career:

Vice Chairman	Japan Hospital Association
Member	National Council of Healthcare for the Aged, Ministry of Health and Welfare
Member	National Council of Health Insurance, Ministry of Health and Welfare
Member	Regulatory Reform Committee, Government of Japan

Chair: Anuwat Supachutikul

The Healthcare Accreditation Institute (Public Organization), Thailand

Chair Information:

Dr.Anuwat Supachutikul was the former CEO of the Healthcare Accreditation Institute (HAI), Thailand. After retirement from the CEO position, he is still active in working as a consultant in healthcare quality and accreditation for the HAI and for many healthcare organizations. He is also the Chairman of the Technical Subcommittee of the Thailand Quality Award program which promote performance excellence for organizations of all sectors. With his background as an orthopedic surgeon and a Master degree of Health Planning and Financing, he has been working for healthcare quality improvement and safety program through the Healthcare Accreditation Program for 20 years. The program, using the concept of 'accreditation as an educational process, not an inspection', is well accepted by all stakeholders and is used as a major machanism for change in the Thai healthcare system. Many patient safety initiatives were also started under this program.

Shin Ushiro

Japan Council for Quality Health Care (JQ) / Kyushu University Hospital, Japan

Impact of Adverse Event Reporting and Learning System and Case Oriented Compensation/Investigation and Prevention System on Enhancing Patient Safety Culture and Mitigating Conflict in Japan

Abstract:

In response to growing concern on patient safety in Japanese society around year of 2000, the Japanese government revised ministerial ordinance to launch national adverse event reporting and learning system in 2004. Through the introductory discussion of the system, JQ was appointed to the operator as it had carried out hospital accreditation with a neutral and scientific view over structural items and quality and safety items. The system covers wide range of adverse events from incident with minimal harm to patient death. It has been successful in disclosing cases that take place in medicine, background elements and preventative measures based on the reporting in transparent manner. Regardless of such inclusive reporting system, patient safety on labor and delivery resulting in cerebral palsy was hardly achieved as conflict took place more often and lead to the shortage of physicians. Therefore, the Japan Obstetric Compensation System for Cerebral Palsy (JOCS-CP) was drawn up as a novel system with such major pillars as no-fault compensation and investigation/prevention. It was urgently launched in 2009, therefore there was no legal rationale. However, the enthusiasm of the Japanese obstetricians enabled the establishment of the system with the help of political parties, the Ministry of Health, Labour and Welfare, scientific societies and professional societies. JQ once again was appointed to the operator of the system because of the rich accomplishment in the field of patient safety. The financial source of the system stems mainly from that of public health insurance system reportedly depicting it as “quasi-public” system. Guardians with cerebral palsy patient have been provided monetary compensation and investigational report since the launch of the system in 2009. Most guardians and childbirth facilities are in favor of the investigational reports primarily because the investigation was conducted by neutral body. It is of note that the Supreme Court of Japan described in the report that it may be effective in reducing lawsuit of obstetrics and gynecology that was denounced as a clinical field rich in conflict including lawsuit.

Keywords:

Adverse Event, Repoting and Learning System, Japan Obstetric Compensation for Cerebral Palsy, No-fault Compensation, Patient Safety

Speaker Information:

Work Experience;

Professor and Director, Division of Patient Safety, Kyushu University Hospital (2014～)
Director and Executive Board Member, Japan Council for Quality Health Care (2011～)
Board Member, International Society for Quality in Health Care (ISQua) (2017～)
Board Member, Japanese Society for Quality and Safety in Healthcare (JSQSH) (2015～)

Education and Training;

March 1997　Doctor of Philosophy (PhD), Kyushu University School of Medicine
March 1991　Medical Doctor (MD), Kyushu University School of Medicine

Social/ Organisational Skills and Competencies;

Prof Ushiro have worked intensively on the launch and implementation of national adverse event reporting and learning system and Japan Obstetric Compensation for Cerebral Palsy in JQ.
At institutional level, his scope has covered wide variety of institutional programs such as incident reporting and learning system, education and training, development of manuals and guidelines related to patient safety and so on. He has even intervened in the proceedings of lawsuit cases so that the case would reach early settlement and restore patient-physician relationship.

Sosuke Kimura

Japan Medical Safety Research Organization

"Medical Accident Investigation System" in Japan

Abstract:

Based on the System enforced in 2015, the Medical Accident Investigation and Support Center [ISC] which belongs to the Japan Medical Safety Research Organization [Medsafe Japan] has been working to prevent recurrences. Serious events resulting in unforeseen death of the patient have been the target of investigation. The decision of "Medical Accident" is entrusted to the concerned hospital under the concept of "Professional Autonomy and Self-Regulation".

We, ISC have published three booklets for the recurrence prevention of medical accidents. The number of the reports from "In-Hospital Investigation" submitted to ISC was over 600 cases in total, during the 2 years and 5 months. ISC decided to take up three themes, "Central Venous Catheterization", "Acute Pulmonary Thromboembolism" and "Anaphylaxis caused by injections". Although the target case report were only 10, 8 and 12 cases each, similar accidents had occurred repeatedly in the past, and in view of the seriousness of the accidents that resulted in death, these three themes have been compiled, and re-investigated by ISC.

ISC's measures to prevent recurrences of accidents are based on the analyses of avoiding accidents that may lead to death. The purpose of this report is to provide recommendations on how to avoid life-threatening accidents. We hope the recommendations will be widely utilized for the secure medicine in each institution.

ISC, and also Medsafe Japan would like to express sincere gratitude to the medical institutions and bereaved families who cooperated in providing an additional information.

Keywords:

medical accident, investigation, in-hospital investigation, prevention recurrence, unforeseen death, professional autonomy and self-regulation

Speaker Information:

An executive director of Japan Medical Safety Research Organization (Medsafe Japan), since 2013.

He graduated from Faculty of Medicine, Tokyo University in 1972, and started his carrier as a cardiovascular surgeon at Mitsui Memorial Hospital. Then he moved to Jichi Medical University and Saitama Medical University for 10, 8 years each, then to National Center for Global Health and Medicine (NCGM). During the 18 years at NCGM, he worked as a Cardiovascular Surgeon, head of the division and the director of the hospital concurrently for the last 5 years. His major is adult cardiovascular surgery, such as coronary artery bypass, acute aortic dissection, and heart valve surgery, as well as mechanical heart support for cardiogenic shock patient. At the same time, he contributed to build up the system of patient safety, as the committee member of Japan Hospital Association. After the retirement from NCGM, he has been involved to manage the "Medical Accidents Investigation System" as the executive director of Medsafe Japan.

Master of Ceremony

Chieko Ikeda

Ministry of Health, Labour and Welfare, Japan

MC Information:

Dr. Chieko Ikeda is the Senior Assistant Minister for Global Health at Japan's Ministry of Health, Labour and Welfare (MHLW). She has been engaged in public health for 30 years since she first joined the MHLW.
Dr. Ikeda was Executive Director of the National Hospital Organization composed of 142 hospitals in 2015, and was previously Vice-Governor of Niigata prefecture. She also was responsible of several divisions at the MHLW and Ministry of Education, Culture, Sports, Science and Technology (MEXT), including Medical Device Policy, International Food Safety and Advanced Medical Technology. From 1999 to 2003, Dr. Ikeda led the technology transfer program at Western Pacific Regional Office of the World Health Organization(WPRO) and activities in Southeast Asia and Pacific region at the Joint United Nations Program on HIV/AIDS(UNAIDS).
She graduated Tsukuba University with a degree on medicine and holds master degrees in public health and science from Harvard Public Health School.

Memo

Organization

Medical Safety Promotion Unit, Health Policy Bureau, Ministry of Health, Labour and Welfare, Japan

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Dr. Satoshi Nakagawa	中川　慧
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Third Global Ministerial Summit on Patient Safety Office

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