Improving safety and quality in nursing care facility through the knowledge on new ICT in medical institutions

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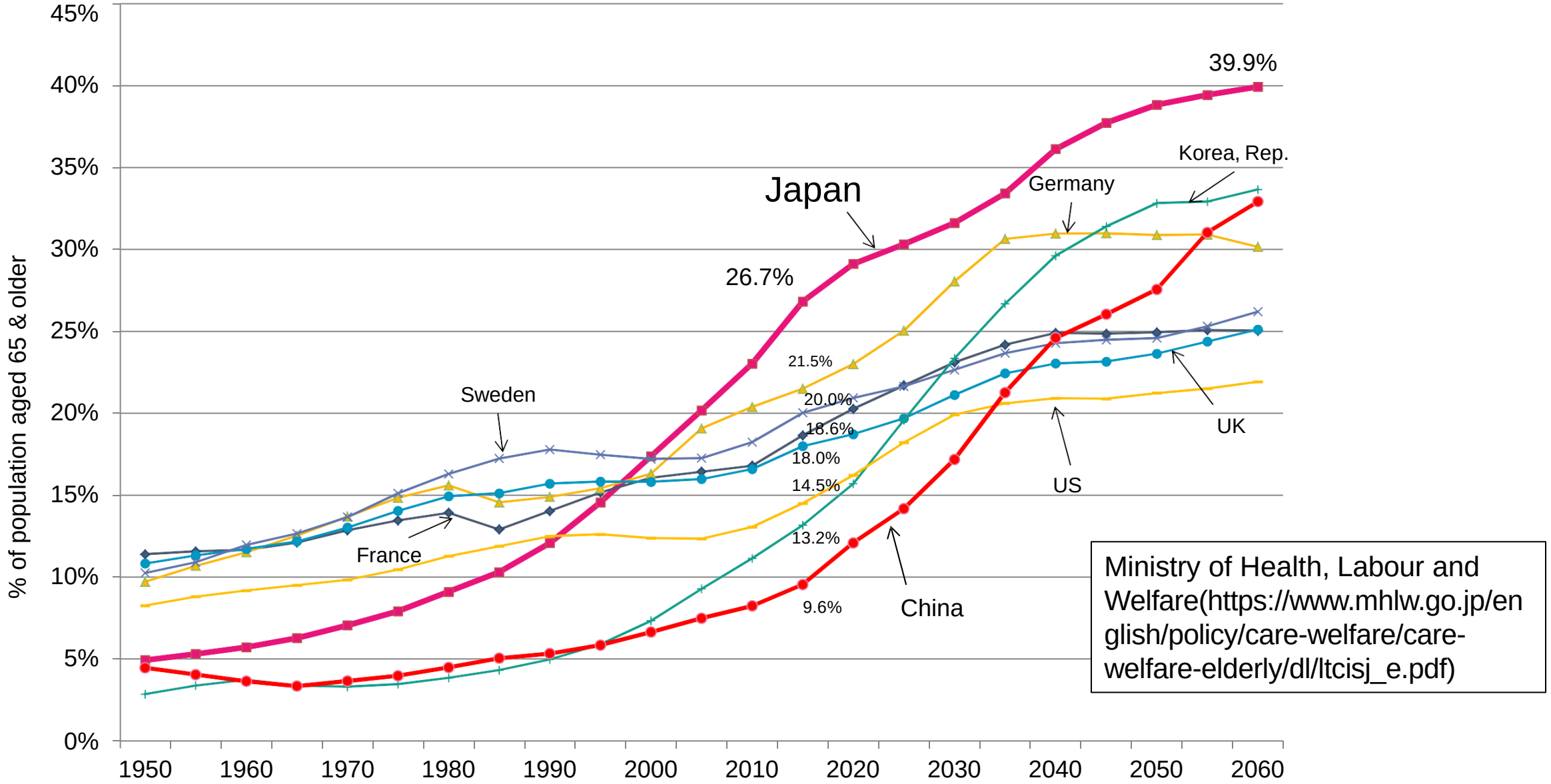
KYUSHU UNIVERSITY

Trajectory of population rate over the age 65



Sources: For Japan – Ministry of Internal Affairs and Communications, Population Census; National Institute of Population and Social Security Research – "Population Projections for Japan (January 2012 estimate): Medium-Fertility & Medium-Mortality Assumption" (Figures as of Oct. 1 of each year) For other countries – United Nations, World Population Prospects 2010

Chronicle of the development of insurance for long-term care

	Aging (%)	Major events related to policies on aging society
1960s Beginning of welfare policies for the elderly	5.7% (1960)	1963 Enactment of the Act on Social Welfare Services for the Elderly ◇ Designated care homes for the elderly ◇ Legislation on home helpers for the elderly
1970s Expansion of healthcare expenditures for the elderly	7.1% (1970)	1973 Free healthcare for the elderly
1980s “Social/Non-medical hospitalization” and “bedridden elderly people” as social problems	9.1% (1980)	1982 Enactment of the Health and Medical Services Act for the Aged ◇ Adoption of the co-payments for elderly healthcare, etc. 1989 Launch of the Gold Plan (10-year strategy for the promotion of health and welfare for the elderly) ◇Promotion of installment of facilities and in-home welfare services
1990s Promotion of the Gold Plan	12.0% (1990)	1994 Establishment of the New Gold Plan (new 10-year strategy for the promotion of health and welfare for the elderly) ◇ Improvement of in-home long-term care
Preparation for adoption of the Long-Term Care Insurance System	14.5% (1995)	1997 Enactment of the Long-Term Care Insurance Act
2000s Introduction and operation of the Long-Term Care Insurance System	17.3% (2000)	2000 Enforcement of the Long-Term Care Insurance System

Delivery of Sustainable Long-term Care in Japan

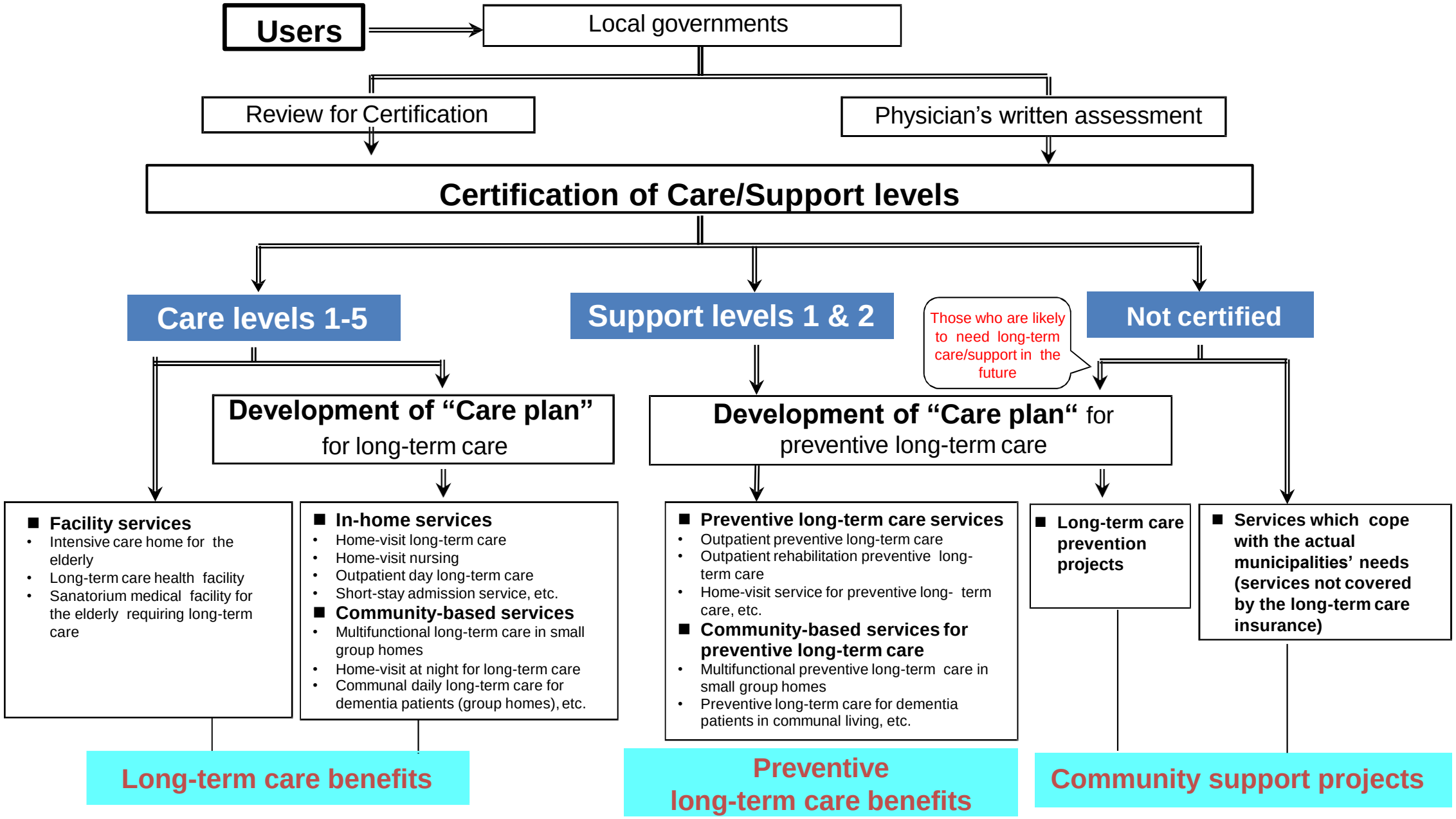
Long-term care as “Family system”

- Delivered by family, relatives etc.
- Quality fluctuated among families.

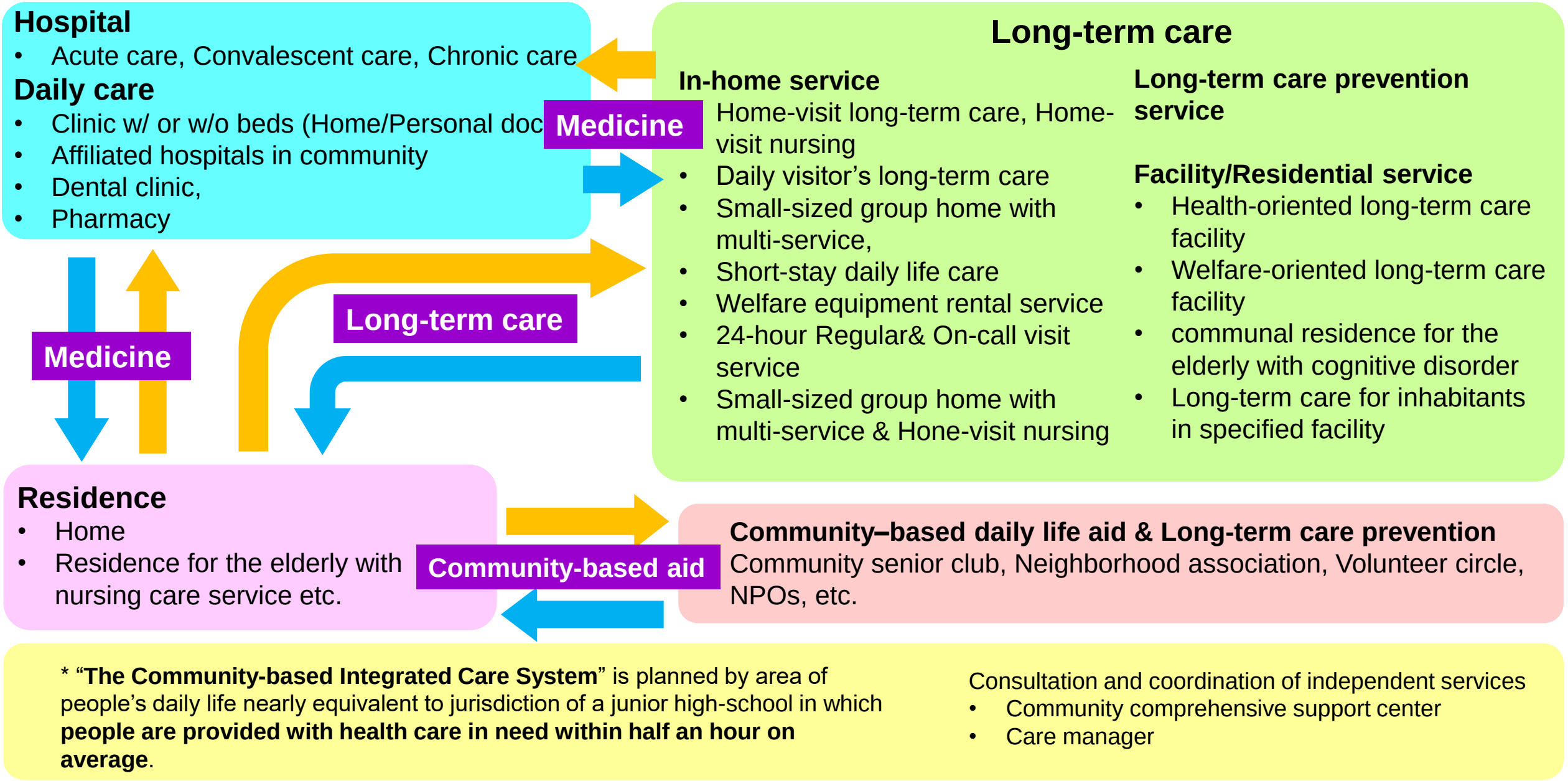
Long-term care as “Social system” backed by national long-term care insurance

- Delivered by designated facility, professionals etc.
- Quality is controlled.

Appropriate allocation system of Long-term Care Services



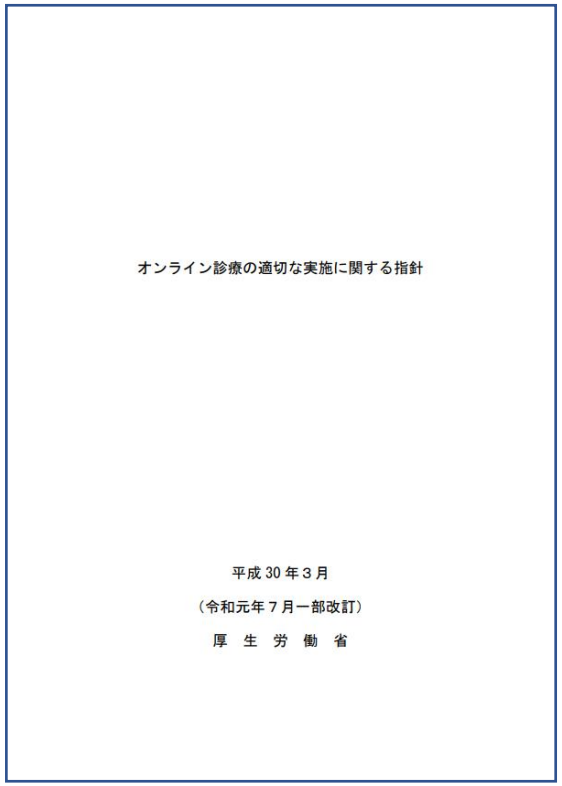
Community-based Integrated Care System



* "**The Community-based Integrated Care System**" is planned by area of people's daily life nearly equivalent to jurisdiction of a junior high-school in which **people are provided with health care in need within half an hour on average**.

Consultation and coordination of independent services
- Community comprehensive support center
- Care manager

Guidance on Telemedicine by the MoH – Table of Contents


オンライン診療の適切な実施に関する指針

平成 30 年３月

（令和元年７月一部改訂）

厚　生　労　働　省

Published in 2018

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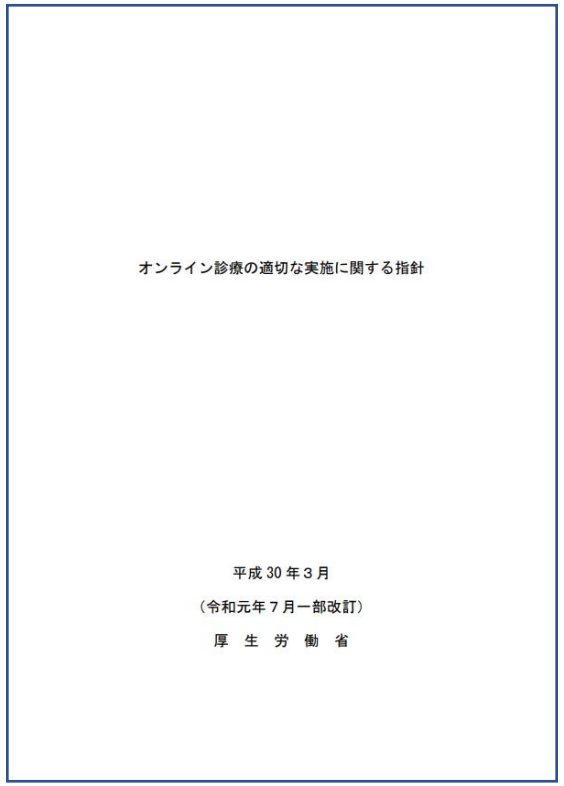
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Ⅴ Practical application

２． Delivery system of telemedicine

1) Physical location; doctor

2) Physical location; patient

3) Telemedicine delivered by nurse etc.

4) Telemedicine delivered by doctor

5) ICT devices settings i.e. security, privacy protection, capability of terminal devices

３． Other relevant requirements

1) Education of doctor/patient

2) Quality assessment of telemedicine/Feedback

3) Aggregation of evidence on effectiveness and safety

JMA's perspective on practical application of telemedicine

Telemedicine is a complementary medicine applied in such cases of restricted access to medicine that could hardly be resolved as;

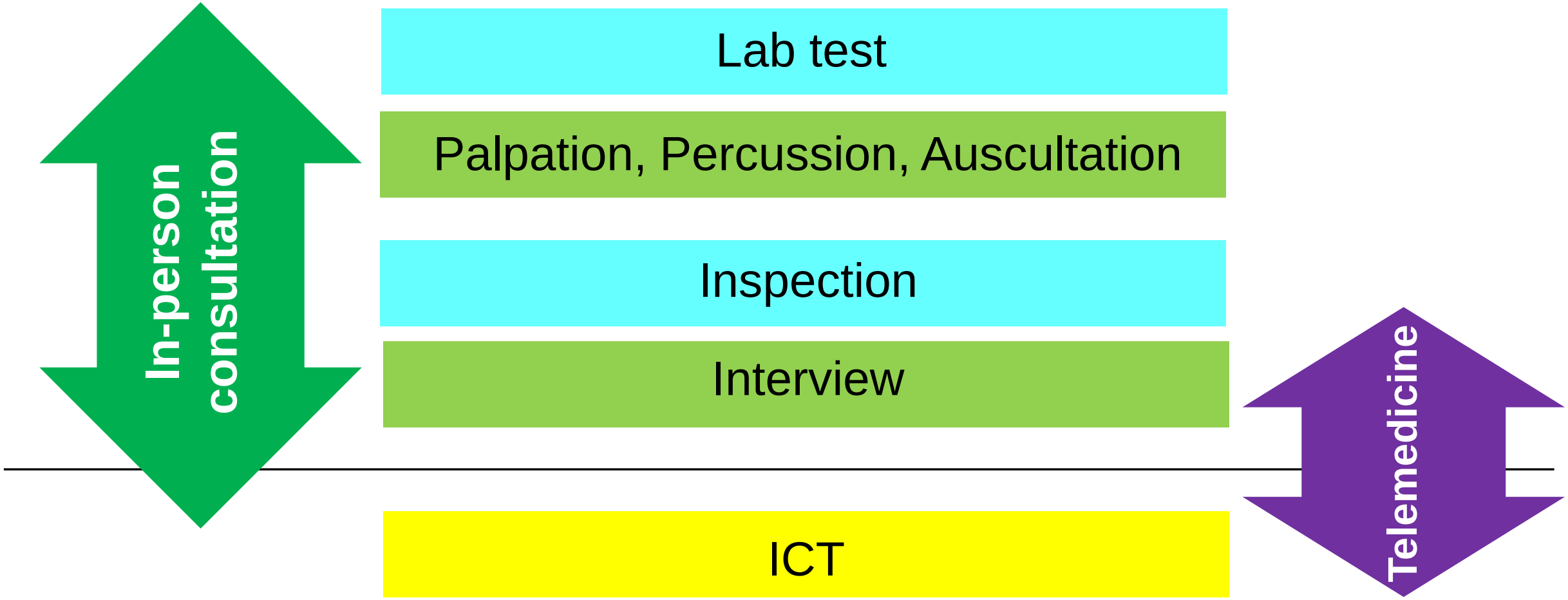
- Geographical restriction of the access i.g. remote islands, rural regions*
- Scarcity of medical facilities to see patients who suffer intractable diseases.*

* Distribution of telemedicine should not facilitate uneven healthcare delivery..

- Restricted access to medical facilities due to such various factors as "home care".
- Tentatively unable to visit medical facility such as women immediately after birth.
- Occasional request of "verbal health consultation" to home doctor/personal doctor**.

**This type of consultation should be allowed for home doctor/ personal doctor. The procedure of the verbal health consultation needs to deliberate in such a way of developing relevant definitions and guidance.

Coverage by in-person consultation and telemedicine



JMA's perspective

- Bills issued to the public healthcare insurance should not be the same between in-person consultation and telemedicine due to difference in coverage.
- No coverage over costs for building and operating "community network" is a challenge to address.

Medicine and long-term care

Hospital
- Acute care, Convalescent care, Chronic care

Daily care
- Clinic w/ or w/o beds (Home/Personal doc
- Affiliated hospitals in community
- Dental clinic,
- Pharmacy

Medicine

Long-term care

In-home service
- Home-visit long-term care, Home-visit nursing
- Daily visitor's long-term care
- Small-sized group home with multi-service,
- Short-stay daily life care
- Welfare equipment rental service
- 24-hour Regular& On-call visit service
- Small-sized group home with multi-service & Hone-visit nursing

Long-term care prevention service

Facility/Residential service
- Health-oriented long-term care facility
- Welfare-oriented long-term care facility
- communal residence for the elderly with cognitive disorder
- Long-term care for inhabitants in specified facility

- Medicine is provided to long-term care patient in need in such different forms as i) consultation at hospital and clinic, ii) home/facility visit-consultation and iii) telemedicine.
- All forms are available in the coverage of the national healthcare insurance system, however, the care has long been deviated to "face-to-face" manner weighing on inspection, palpation, percussion, auscultation et cetera.

Medicine and long-term care

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Long-term care prevention service

Facility/Residential service
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- Telemedicine has been principally allowed in such specific settings as rural areas with scarcity of healthcare resources, in-home patient, intractable disease(s) to which there are few specialists et cetera.
- Payment of national healthcare insurance to telemedicine has been more strictly restricted than in-person consultation i.e. outpatient consultation and home-visit consultation because of the conventional idea that telemedicine is less effective.

Telemedicine amid pandemic

Mar 31, 2020	**Statement by then Prime Minister Abe** Telemedicine needs to be promoted and enhanced not only for protecting patients but for guarding physicians, nurses and other medical professionals from contracting Covid-19. I hope that the urgent measures to grapple with current Covid-19 pandemic have to be compiled in **the panel on promoting deregulation** installed in the prime minister's office with utmost sense of crisis.
Apr 2, 2020	**The panel on promoting deregulation** – Special task force on curbing novel coronavirus infection " Prime minister's instruction is urging to take emergent measures with a sense of urgency and crisis. What the relevant ministries and professional societies has done on telemedicine et cetera is not sufficient to meet the prime minister's request".

* Synthesis of meeting record

"JMA's perspective on telemedicine" by Japan Medical Association(https://www.med.or.jp/dl-med/teireikaiken/20200924_1.pdf)

Meeting in MoH on revising guidance on appropriate telemedicine

Mar 11, 2020	Delivering first consultation with patient suspicious of contracting Covid-19 may incur such risks as further contraction to others and increase in fatality through upgrading severity for reasons as follows; Unable to provide appropriate lab test i.e. PCR for precise diagnosis Unable or highly difficult to assess severity by inspection and interview Difficult to capture such other ailments as bronchial asthma and other contract diseases
Apr 2, 2020	Case1: Patient with diagnosed with a certain disease under long observation lately manifested different symptoms to be examined and medicated. Case2: Patient with history of consultation lately manifested different symptoms to be examined and medicated. Case3: Patient with no history of consultation lately manifested symptoms to be examined. Case4: Patient with no history of consultation lately manifested symptoms to be examined and medicated with the referral letter from physician in charge of regular follow-up of the patient. Deliberating above four case studies, strong oppositions were raised by the experts in the meeting stating, “It is highly risky to see patient with no history of consultation and prescribe medicine.” “It is impossible to make correct diagnosis to patient with no history of consultation by procedure without lab test.” “Clearly oppose to telemedicine for patient with no history of consultation.”.

* Synthesis of meeting record

Telemedicine amid pandemic

Apr 3, 2020	**The panel on promoting deregulation: Special task force on curbing novel coronavirus** requested the MoH expert meeting. “Current situation is the state of urgency. With that, the panel requests the MoH meeting to make constructive argument by all means.” “Opposition of the MoH expert panel is never based on the current state of urgency.” “The panel urges the MoH meeting to conclude that telemedicine is available during the current urgent state if all the nation is in favor of it. * Synthesis of meeting record
Apr 7, 2020	The panel on promoting deregulation concluded tentative deregulation of telemedicine to patient on the first consultation.
Apr 10, 2020	MoH administrative notice on telemedicine of first consultation was issued. All the cases studied in the MoH meeting were treated as subjects to telemedicine. Case1: Patient with diagnosed with a certain disease under long observation lately manifested different symptoms to be examined and medicated. Case2: Patient with history of consultation lately manifested different symptoms to be examined and medicated. Case3: Patient with no history of consultation lately manifested symptoms to be examined. Case4: Patient with no history of consultation lately manifested symptoms to be examined and medicated with the referral letter from physician in charge of regular follow-up of the patient.

JMA’s perspective → Despite strong oppositions, telemedicine was approved for first consultation of patient on condition of tentative trial during the urgent situation. After pandemic, the measure should be reviewed.

Consultation fee* in the national healthcare insurance system (Before Covid-19)

* Fee for Mon-Fri and Business hour

** 1point=10JPY

i. In-person consultation

- Consultation fee, in-person (Initial visit); 288 points**
- Consultation fee, in-person (Subsequent visit); 73 + Regular maintenance fee; 87-1,681

Consultation fee* in the national healthcare insurance system (Before Covid-19)

* Fee for Mon-Fri and Business hour

** 1point=10JPY

*** Simple Q&A

ii. Telemedicine

- Online consultation fee (Initial visit); **None**
- Online consultation fee (Subsequent visit, chargeable only once a month); 71 + Regular maintenance fee; 100
- Telephone inquiry*** fee (Subsequent visit); 73 + Regular maintenance fee; **None**

(Restriction on frequency of telemedicine)

- Online (times of charge) / Online plus In-person (times of charge) = 10% or less i.e. **Few institutions provide “only telemedicine”**.

Before Covid-19

- Telemedicine was **hardly profitable** in national healthcare insurance system in Japan.
- It has been seen in such limited settings as healthcare in remote place, for patients with intractable disease et cetera.

Emergence of Covid-19 in 2020

- Patients under in-person care hardly visit clinics and hospitals.
- Demand of telemedicine mostly through telephone conversation rapidly grew in clinics and hospitals.

During Covid-19 – As of today

- Under the leadership by the Prime Minister, tentative measures were taken to **make telemedicine profitable**.

Consultation fee* in the national healthcare insurance system (During Covid-19)

* Fee for Mon-Fri and Business hour

** 1point=10JPY

*** Simple Q&A

i. In-person consultation

- Same as the “Before Covid-19”

ii. Telemedicine

- **Consultation fee (Initial visit); 214**

For patient who newly get sick during Covid-19

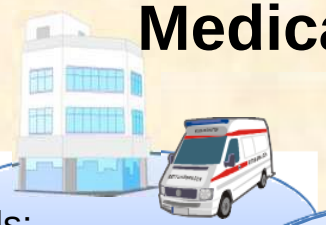
- Online consultation fee (Subsequent visit, chargeable only once a month); 71 + Regular maintenance fee; 100
- Telephone inquiry*** fee (Subsequent visit); 73 **+ Regular maintenance fee; 147**

For patient who are reluctant to visit clinics and hospitals during Covid-19

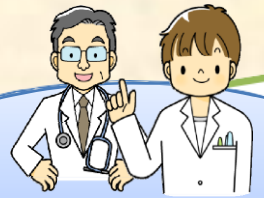
(Restriction on frequency of telemedicine); Halted

Community-based Integrated Care System

Medical Care



Hospitals:
Acute phase,
recovery phase,
chronic phase

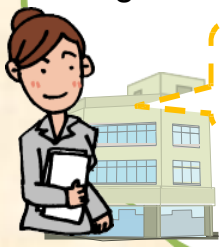


Outpatient/in-patient care

Daily health care:

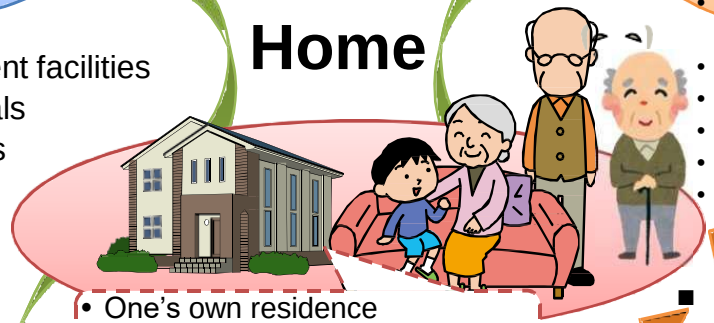
- PCP, clinics with in-patient facilities
- Regional affiliate hospitals
- Dental care, Pharmacies

- CommunityGeneral Support Center
- Care manager



Provides consultation service and service coordination.

Home



- One's own residence
- Senior residence offering services, etc.

Visits / Moving in

Long-term Care

■ In-home services:

- Home-Visit Long-Term Care, Home-Visit Nursing, Outpatient Day Long-Term Care
- Multifunctional (Long-Term Care) Small Group Home
- Short-Term Admission for Daily Life Long-Term Care
- Equipment for Long-Term Care covered by Public Aid
- 24-hour Home-Visit Service
- Combined Multiple Service (Multifunctional Long-Term Care in a Small Group Home & Home-Visit Nursing)

■ Preventive Long-Term Care Services

■ Facility/Residence services:

- Nursing-care homes
- Geriatric health services facilities
- Communal-living care for patients with cognitive disorder
- Daily-life care for persons at government-designated facilities etc.

Livelihood support/ preventing long-term care

Senior clubs, residents' associations, volunteer groups, NPOs, etc.

* The Community-based Integrated Care System is conceived in units of every-day living areas (specifically equivalent to district divisions for junior high-schools) in which necessary services can be provided within approximately 30 minutes.

Quality assurance of long-term care

Quality assurance programme	Structure	Process	Outcome
Regulation by licencing operator/certifying phisical structue of facilities	- Minimum requirements on the number of care givers, equipments, etc.	- Minimum requirements on delivery of care (Service delivery with documented concent by resident/family, Tailored care planning requirement, etc.)	None
Regular inspection	- Inspection to breaches of requirements, Issuance of decipinary diectives	- Diciplinary action on comprehensive care management	None
Compulsory disclosure on operational data on long-term care facility	- Data on i) Equipment ii) Number of caregivers iii) Resident, etc.	- Data on; i) Status of quality improvement (Production and utilization of resident's life record, etc.) ii) Cooperative and complementay system with other relevant facilities, etc.	None
Financial incentives through national long-term care insurance payment	- Additional fee to specific services	- Additional fee on i) facility-visit rehabilitation/nursing, etc. ii) Other cooperative and complementary activities	- Additional fee on general accerelation of returning home/accerelation of returning home through medical care

A registered nurse vindicated at appeal court of criminal oversight in relation to resident's "accidental suffocation"

- A resident died from asphyxia due to failed ingestion of "Donut" after meal.
- District court sentenced guilty of the nurse's care.
- Appeal court overturned it.

東京高裁に入廷する弁護士ら（28日、東京都千代田区で）

窒息「予見可能性低い」

特養逆転無罪

東京高裁 弁護側の主張認める

安曇野市の特別養護老人ホームで2013年、入所者の女性（当時85歳）に誤ってドーナツを食べさせ、死亡させたとして、業務上過失致死罪に問われた准看護師、山口けさえ被告（60）に対する28日の控訴審判決で、東京高裁は罰金20万円とした一審・長野地裁松本支部判決を破棄し、無罪を言い渡した。大熊一之裁判長は弁護側の主張をほぼ認め、支援者からは「利用者の希望に沿った介護現場に戻ってほしい」との声が上がった。

「主文。原判決を破棄する。被告人は無罪」

午後3時過ぎ、判決が読み上げられると、黒いジャケット姿の山口被告はハンカチで額や首の辺りを押さえながら、大熊裁判長を真っすぐに見つめた。閉廷後、山口被告はマスク越しに笑顔を見せ、傍聴席に向かって深く一礼した。

1審判決では、女性の死因はドーナツで喉を詰まらせたことによる窒息と認定。おやつは約1週間前にドーナツからゼリーに変更されていたが、山口被告は引き継ぎ資料で確認しなかった過失があるとした。

ただ、高裁判決では、女性には窒息の要因の一つである嚥下障害はなく、「ドーナツによる窒息の危険性は低かった」と指摘。おやつが変更されたことについても、「看護師と介護士が確認する日誌に記載はなかった」とした。

また、ドーナツを食べたことで窒息して死亡するという「予見可能性は相当に低かった」とし、「おやつの変更を確認せずに提供したことが刑法上の注意義務に反するとはいえない」と結論づけた。

今年1月の控訴審第1回公判では、弁護側が死因を調べるため、新たな証拠を提出したがほとんどが却下されて結審した。大熊裁判長は1審判決について、「明らかな事実誤認がある以上、検討に時間を費やすのは相当ではなく、速やかに破棄すべきだ」とした。

判決後、国会内で開かれた記者会見で山口被告は、「みなさんの支援のおかげで真実が証明されました。6年半という長い時間、支えていただき、本当にありがとうございました」と涙を浮かべた。

弁護団長を務めた木嶋日出夫弁護士(73)は、「ほぼ全面的に弁護側の主張を是とした」としたうえで、「心配なことはやらないという消極的な介護ではなく、介護を前進させるため、判決が役立つことを願っている」と強調した。

山口被告が働く特別養護老人ホームを運営する「協立福祉会」の高津隆行事務局長(46)は、読売新聞の取材に対し、「至極まっとうな判断で、主張してきた通りに認められた」と評価。施設では現在、おやつはゼリー状にし、食べることを主としたレクリエーションも減らしているといい、「利用者の希望に沿った生活を支える介護現場に戻ってほしい」と訴えた。

◆東京高裁 判決の骨子

▽女性に嚥下障害は認められず、窒息の危険が低かった

▽おやつの形態変更は准看護師の通常業務の中で容易に知り得る

▽おやつの形態を確認せずドーナツを提供したことが刑法上の注意義務に反するとはいえない

YOMIURI SHIMBUN July 29, 2020

JQ's Projects on Quality and Safety Improvement

- Hospital Accreditation
- Patient Safety Promotion Group of Among Accredited Hospitals
- Education and Training on Patient Safety
- EBM Medical Information Distribution Project (Minds)
- **Nationwide Adverse Events Reporting System of Medical Instutions**
- **Nationwide Near-miss Event Reporting System of Community Pharmacy**
- The Japan Obstetric Compensation/Investigatiuon and Prevention System for Cerebral Palsy
- National Quality Indicator (QI) Measurement Project

Patient representatives participate in the operation of most projects.

Japan Council for Quality Health Care
公益財団法人 日本医療機能評価機構

Overview of the nationwide adverse event reporting/learning system (2004 -)

Adverse event

Hospitals (Mandatory)

-University Hospitals
-National Hospitals
etc.

Hospitals (Voluntary)

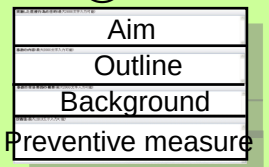
Near-miss

Hospitals (Voluntary)

Web-based reporting

①Cording

②Text



On-site visit

（Voluntary survey）

Japan Council for Quality Health Care

Aim
Patient safety and prevention of accident
（No blame）

Steering Committee
(Experts, Patient representative)

Expert Panel

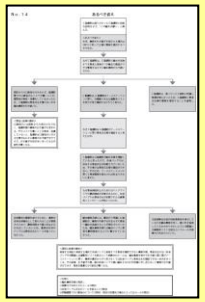
Secretariat

Annual/Quarterly report

Monthly alert

Database

Training program (RCA)

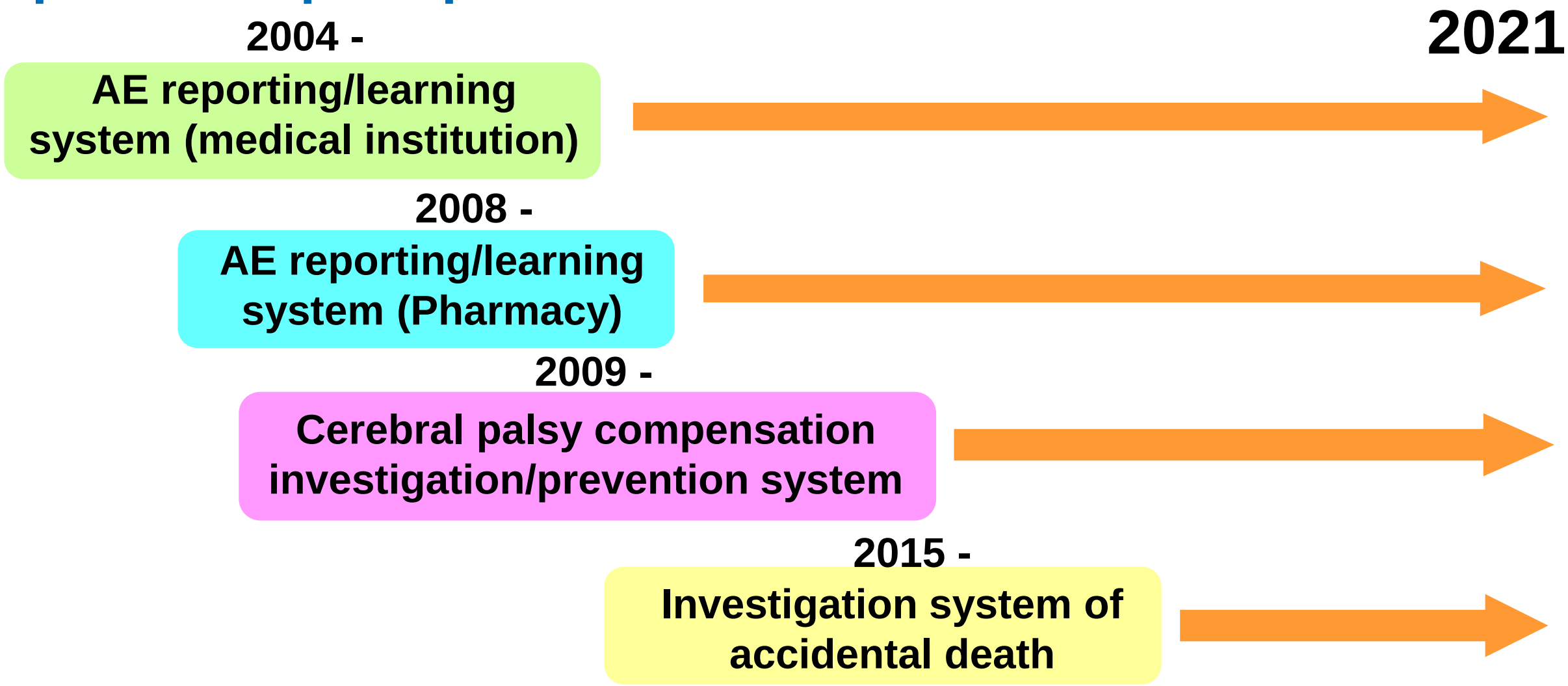


General public

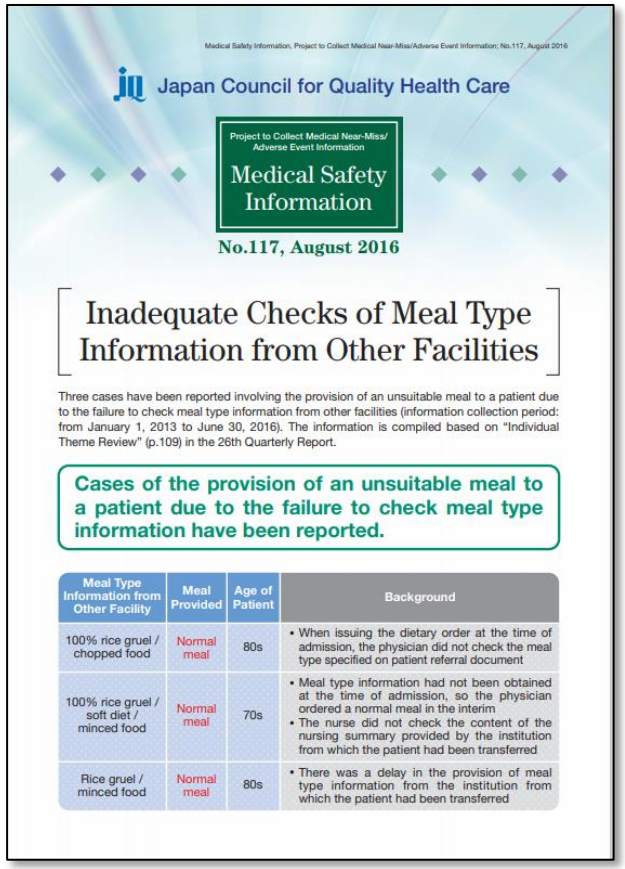
Health care professionals/ facilities

Government

Nationwide reporting/investigation/learning system with public or quasi public nature



Monthly alert



Medical Safety Information, Project to Collect Medical Near-Miss/Adverse Event Information; No.117, August 2016

Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

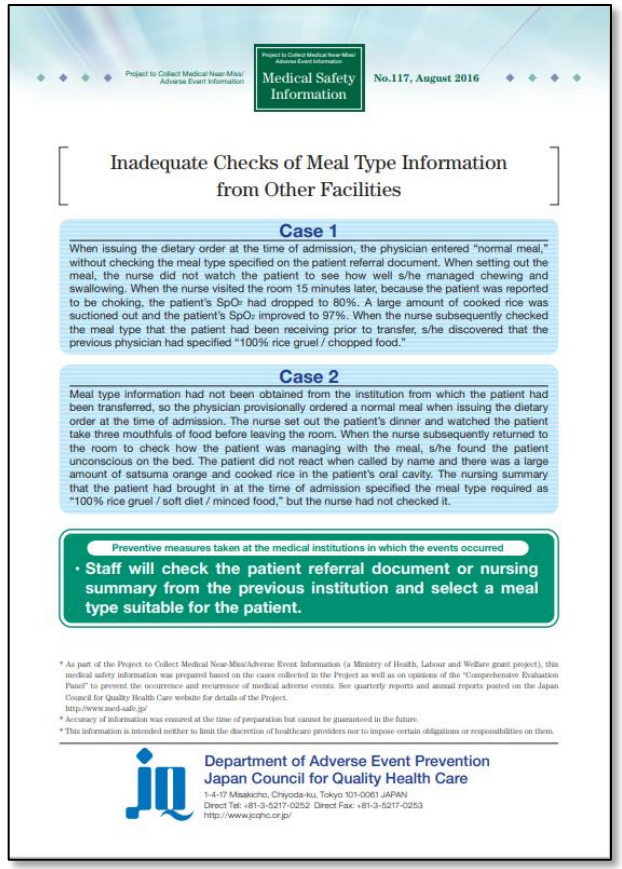
No.117, August 2016

Inadequate Checks of Meal Type Information from Other Facilities

Three cases have been reported involving the provision of an unsuitable meal to a patient due to the failure to check meal type information from other facilities (information collection period: from January 1, 2013 to June 30, 2016). The information is compiled based on "Individual Theme Review" (p.109) in the 26th Quarterly Report.

Cases of the provision of an unsuitable meal to a patient due to the failure to check meal type information have been reported.

Meal Type Information from Other Facility	Meal Provided	Age of Patient	Background
100% rice gruel / chopped food	Normal meal	80s	• When issuing the dietary order at the time of admission, the physician did not check the meal type specified on patient referral document
100% rice gruel / soft diet / minced food	Normal meal	70s	• Meal type information had not been obtained at the time of admission, so the physician ordered a normal meal in the interim • The nurse did not check the content of the nursing summary provided by the institution from which the patient had been transferred
Rice gruel / minced food	Normal meal	80s	• There was a delay in the provision of meal type information from the institution from which the patient had been transferred



Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.117, August 2016

Inadequate Checks of Meal Type Information from Other Facilities

Case 1

When issuing the dietary order at the time of admission, the physician entered "normal meal," without checking the meal type specified on the patient referral document. When setting out the meal, the nurse did not watch the patient to see how well s/he managed chewing and swallowing. When the nurse visited the room 15 minutes later, because the patient was reported to be choking, the patient's SpO_2 had dropped to 80%. A large amount of cooked rice was suctioned out and the patient's SpO_2 improved to 97%. When the nurse subsequently checked the meal type that the patient had been receiving prior to transfer, s/he discovered that the previous physician had specified "100% rice gruel / chopped food."

Case 2

Meal type information had not been obtained from the institution from which the patient had been transferred, so the physician provisionally ordered a normal meal when issuing the dietary order at the time of admission. The nurse set out the patient's dinner and watched the patient take three mouthfuls of food before leaving the room. When the nurse subsequently returned to the room to check how the patient was managing with the meal, s/he found the patient unconscious on the bed. The patient did not react when called by name and there was a large amount of satsuma orange and cooked rice in the patient's oral cavity. The nursing summary that the patient had brought in at the time of admission specified the meal type required as "100% rice gruel / soft diet / minced food," but the nurse had not checked it.

Preventive measures taken at the medical institutions in which the events occurred

- **Staff will check the patient referral document or nursing summary from the previous institution and select a meal type suitable for the patient.**

* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of the "Comprehensive Evaluation Panel" to prevent the occurrence and recurrence of medical adverse events. See quarterly reports and annual reports posted on the Japan Council for Quality Health Care website for details of the Project.
http://www.med-safe.jp/
* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.
* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

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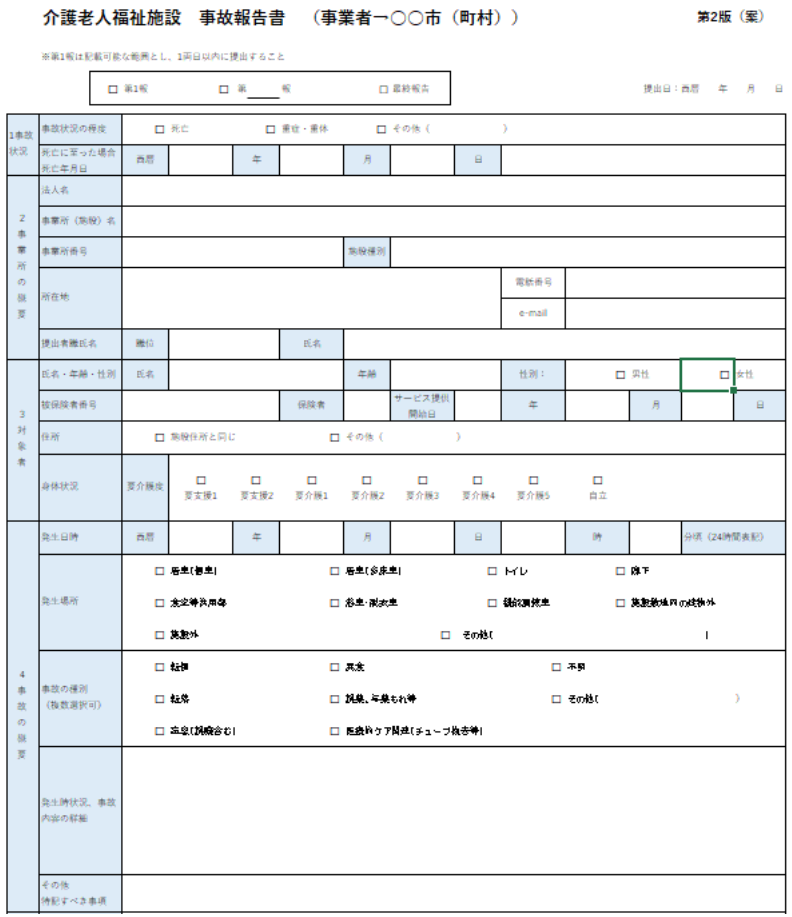
- On admission, the physician entered "normal meal" without checking the meal type specified on the patient referral document.
- The nurse did not observe the patient to see how well s/he managed chewing and swallowing.
- The patient was reported to be choking, the patient's SpO2 had dropped to 80%.
- A large amount of cooked rice was suctioned. The meal type should have been "100% rice gruel / chopped food" instead of "normal meal".

Japan Council for Quality Health Care
公益財団法人 日本医療機能評価機構

JQ's study group on reporting and learning system of incident of long-term care settings funded by the MoH (2018-)



介護老人福祉施設　事故報告書　（事業者ー○○市（町村））　第2版（案）

※第1報は記載可能な範囲とし、1両日以内に提出すること

□ 第1報　□ 第＿＿報　□ 最終報告　提出日：西暦　年　月　日

1事故状況
- 事故状況の程度　□ 死亡　□ 重症・重体　□ その他（　）
- 死亡に至った場合 死亡年月日　西暦　年　月　日

2事業所の概要
- 法人名
- 事業所（施設）名
- 事業所番号　施設種別
- 所在地　電話番号　e-mail
- 提出者職氏名　職位　氏名

3対象者
- 氏名・年齢・性別　氏名　年齢　性別：□ 男性 □ 女性
- 被保険者番号　保険者　サービス提供開始日　年　月　日
- 住所　□ 施設住所と同じ　□ その他（　）
- 身体状況　要介護度　□ 要支援1 □ 要支援2 □ 要介護1 □ 要介護2 □ 要介護3 □ 要介護4 □ 要介護5 □ 自立

4事故の概要
- 発生日時　西暦　年　月　日　時　分頃（24時間表記）
- 発生場所　□ 居室（個室）　□ 居室（多床室）　□ トイレ　□ 廊下　□ 食堂等共用部　□ 浴室・脱衣室　□ 機能訓練室　□ 施設敷地内の建物外　□ 施設外　□ その他（　）
- 事故の種別（複数選択可）　□ 転倒　□ 誤薬　□ 不明　□ 転落　□ 誤嚥、窒息もれ等　□ その他（　）　□ 出血（誤嚥含む）　□ 医療行為関連（チューブ抜去等）
- 発生時状況、事故内容の詳細
- その他 特記すべき事項

- Reporting form is being developed.
- The form of R/L system of medical institution and pharmacy were rigorously reviewed.
- Specific items for long-term care facility are added such as;

"Degree of frailty", "Allotriophagy" in event type, "Referred to medical facility by ambulance/walk-in", "Date of report to family", "Damage payment", "Report to authorities i.e. local government/Police"

Takeaways

- As long-term care burden grew at home, Japan launched a national insurance system for long-term care in 2000.
- Residents under long-term care principally need to see physicians as in-person care has been attached importance to.
- Telemedicine has been available, but less refunded in national healthcare insurance. It has been limitedly seen in settings as remote care, care for intractable disease etc.
- Covid-19 pandemic dramatically changed the situation. Telemedicine is allowed more payment during the pandemic. Payment after Covid-19 is still uncertain.
- Regarding safety in long-term care facilities, they are vulnerable to accusation, lawsuit etc. in Japan.
- In an attempt to enhance quality, safety and transparency, JQ and the MoH is studying incident reporting and learning system of long-term care facility.