6th World Congress of Clinical Safety (6WCCS)

- Safe Environment and Progressive Skills Toward Smart Healthcare
--- Based on Quality and Quantity Aspects

Date: 6 (Wed) - 8 (Fri) September 2017

Venue: Ambasciatori Palace Hotel, Rome, Italy

Proceeding

By

International Association of Risk Management in Medicine

(IARMM)

http://www.iarmm.org/6WCCS/

Greetings

The Rome Congress is organized by IARMM to develop highly-advanced safe and clean science and technology. The congress covers a wide range of safety topics, such as clinical safety (patient safety, medication safety, medical device safety), infectious disease outbreak, disaster healthcare, clinical crisis governance, environmental health & safety, food safety, and other related safety subjects.

After the previous Congresses, 2012 in London, 2013 in Heidelberg, 2014 in Madrid, 2015 in Vienna, and 2016 in Boston, it is a time for 6th Congress 2017 in Rome, Italy.

We are sure that the Congress will assist the world wide exchange of knowledge and skills in this specialist area. Let's all join together at the Rome Congress to meet and share information with your colleagues in a heart of the Ancient Roman Empire.

Sincerely,

IARMM

(Official language) English, No translation to other languages.

Free WI-FI is available.

(Congress place)

Ambasciatori Palace Hotel, Rome, Italy
Via V. Veneto 62 - 00187 Rome, Italy
Tel: + +39 06 47493
http://www.royalgroup.it/ambasciatoripalace/en

Registration desk:	Lobby of Room “Ambasciatori” on the ground floor
Lecture hall:	Room “Ambasciatori” on the ground floor
Poster presentation space:	Room “Palazzo” on the mezzanine floor
Lunch:	Room “Palazzo” on the mezzanine floor

(Onsite registration desk)
Opening hour of the onsite registration desk: from 9:00 to 17:30, 6 Sep. 2017
Opening hour of the onsite registration desk: from 9:00 to 17:30, 7 Sep. 2017
Opening hour of the onsite registration desk: from 9:00 to 17:30, 8 Sep. 2017

(Poster)
6 Sep. (Poster discussion time: 16:00-17:00)
7 Sep. (Poster discussion time: 16:05-17:00)
8 Sep. (Poster discussion time: 15:40-16:40)
Each poster should be displayed from 13:30 to the end time of poster discussion.

(1) Food supply at Room “Palazzo” on the mezzanine floor.
Lunch and coffee break services are available for presenters and the audiences who paid the conference registration fee.

(2) All delegates should register at the onsite conference desk in the following hours.
From 9:00 to 17:00, during the conference days.
Nname card, and participation certification letter: You can take them.

- Please note that we have not any onsite registration desk before 6th September 2017.
- Please hang your name card during the conference days.

The abstract book in internet is delivered to the registered delegates. The Congress hall has free WIFI service, so that you can see all abstracts in internet during the Congress period.

There is no print version of the abstract book.

International Association of Risk Management in Medicine (IARMM)

4-7-12-102 Hongo, Bunkyoku, Tokyo, Japan
(Tel/Fax) +81-3-3817-6770
head.office01@iarmm.org

Registration Manner

(€ : euro)

Early bird registration (till 15 August 2017	Price	Price
	IARMM non-member	IRMPM member and student
Delegate Fee for 3 days (The price is tax free.)	€550	€450
Delegate Fee for 2 days (The price is tax free.)	€400	€300
Delegate Fee for 1 day (The price is tax free.)	€200	€150

(Presenter) From 1 April 2017 to 31 May 2017
(Audience without a visa for Italy) From 1 April 2017 to 15 August 2017
(Audience requested a visa for Italy) From 1 April 2017 to 15 July 2017

(Registration homepage):
http://www.iarmm.org/6WCCS/conference-payment.html

*The Proceedings (electronic version) is delivered to all delegates in a special website.
The Proceedings (print version) is not released..

* The dinner is not scheduled.

*Delegate fees cover all printed materials (e-version proceedings, journals, etc), catering for coffee breaks, lunch, and the other registration services. It doesn't include dinner.

*The delegate fee for the remote participant is 400 ERU.

The registration is closed from 15 Aug 2017 to 5 Sep 2017.

Onsite registration (6, 7, 8 Sep 2017)	Price	Price
	IARMM non-member	IRMPM member and student
Delegate Fee for 3 days (The price is tax free.)	€650	€510
Delegate Fee for 2 days (The price is tax free.)	€500	€360
Delegate Fee for 1 day (The price is tax free.)	€250	€180

*The Proceedings (electronic version) is delivered to all delegates in a special website.
The Proceedings (print version) is not released..

* The dinner is not scheduled.

*Delegate fees cover all printed materials (e-version proceedings, journals, etc), catering for coffee breaks, lunch, and the other registration services.

Major Organizers

Organizing Committee

President: Ryoji Sakai (IARMM President. Dr. Med. Hon. Prof. SU, former Profs. TWU, EPFL, USM, etc., Tokyo, Japan)
Job Harenberg (Past Co-President of 2 & 4WCCS. em Prof. Dr. Med. Ruprecht- Karls-University Heidelberg, Germany)
Maria Angeles Cuadrado Cenzual (Prof. MD, Dept Med., Complutense University of Madrid, Spain)
Bartoccioni Filippo (Prof. MD Azienda Sanitaria Locale (ASL) Viterbo, Italy)
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Rangar Lofstedt (Prof. Dr. King's Collage London, UK)
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Dean Ian Curren (Prof. NHS Health Education England, Queen Mary, University of London, The London Deanery, UK)
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Hajime Sato (Director, National Institute of Public Health, health crisis management,Saitama, Japan)
Enric Macarulla (Prof. Surgery, Autonomous Univ. Barcelona. Hospital Igualada, Igualada, Barcelona, Spain)
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Dean Fathers (Prof. Chair at EIGA, UK) / Peter McCulloch (Oxford University, UK)
Dietmar Ausserhofer (Basel University, Switzerland /
Eric Poon (former Assoc. Prof. MD. Harvard University, medication safety, USA)
Haytham Kaafarani (Asist. Prof. MD. Harvard University, surgery, Boston, USA)
KONE Adjoua-Victoria (Paris University Hospital. France) / Matthieu Colom (University of Lion, France)
Güler Demirbas Uzel (Dr. INTERNATIONAL ATOMIC ENERGY AGENCY, Seibersdorf, Austria)
Ahmad Elsheikh (Director of Quality and Patient Safety, Makkah, Ministry of Interior, Saudi Arabia (patient safety)
Amanda Steane (Essential Care advisor, UK) / Mary P Tully (University of Manchester, UK)
Dina Baroudi (Dr. M S Basharahil hospotal, Saudi Arabia)
Artur Chelmicki (Specialista ginekologii i położnictwa, Poland) / Mustafa Atac (CEO, Redstar Aviation, Turkey)
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Marcel Westerlund (Central Hospital of Växjö, Sweden)
Rusli B. Nordin (Prof. & Chair. Past President Asia Congress of IARMM, Malaysia)
Alexander Pivovarov (Prof. & Dean. Dr. President of Ukraine Society in IARMM, Ukraine)
Dean Fathers (Prof. Centre for Health Enterprise, UK) / Hoss A Dowlat (Vice-President, PharmaBio Consulting, UK)
Claudia Megele (Assoc. Prof. University of Hertfordshire & Chair @MHchat, @SWSCmedia, @U4Change, UK)
Linda Cairns (EPP CIC, UK) / Levette Lamb (Regional Patient Safety Advisor, UK)
Aurelian UDRISTOIU (Dr. Spitalul Judetean de Urgenta Targu Jiu, Romania)
Richard Ayres (EMEA Global Comparators at Dr Foster Intelligence. UK)
Issam El Amri (MD. President, Association Tunisienne d'Aide Aux Victimes d'Erreurs Médicales, Tunisia)
Drshwetha Akshaya (Assistant Executive Director, Hamad Medical Corporation, Qatar)
João Santos-Lucas (MD. U. of North Carolina-Singapore, Singapore)
Rim Mabrouk (Faculty of Nursing at Damanhour University, Egypt)
Shoumen Datta (former MIT, USA) / Abhay Chopada (BMI Clementine Churchill Hospital, USA)

Transportation & Map to Palace

http://www.royalgroup.it/ambasciatoripalace/en/position

The hotel is close to the US Embassy, the Italian Ministry of Economic Development, and the Ministry of Work, as well as some of Rome's major sights.

BY TAXI
It takes 5 minutes from Rome Termini (Rome Central Station) by taxi.
BY PLANE
There is no shuttle bus from airports to the hotel.
From Fiumicino - Leonardo da Vinci Airport, take the Leonardo Express train directly to Rome's Termini station
From Ciampino Airport, take the Terravision coach to the centre of the city and get off at Via Marsala (Termini railway station).
From the station, take Rome's Metro Line A to Barberini, or take the 175 bus to the Via Veneto stop.
BY TRAIN
From Rome's Termini station, take Rome's Metro Line A and get off at Barberini, or take the 175 bus to the Via Veneto stop.
BY CAR
The hotel is 11 km from the GRA - Grande Raccordo Anulare orbital motorway's Exit 8 Settebagni-Salaria.
Take the Exit 8, then follow Via Salaria for 8.5 km.
Go straight on Via Giovannelli and turn left in Largo Tartini, then go straight on Via Aldega for 85 m.
Turn left in Via Paisiello then straight on Via Pinciana until Piazzale Brasile. Turn left and cross Porta Pinciana arches. Follow Via Vittorio Veneto for 250 m.

Meals

Lunch & Coffee Breaks

Place: Guests may enjoy lunch Room "Palazzo" on the mezzanine floor
The fees are included into your congress registration fee.
There are several different menus so that you can choose your food.

The Hotel has other coffee bars and restraints, but the fees are charged by your expenses.

Timetable

6 September 2017		
	Room "Ambasciatori" on the ground floor	Room "Palazzo" on the mezzanine floor
10:00 - 11:50	Special Lectures Oral presentation	Break
11:50 - 13:00	Break	Lunch
13:00 - 17:00	Oral presentation (till 16:00)	16:00 - 17:00 Poster Discussion

Poster display: 13:30-17:00

7 September 2017		
	Room "Ambasciatori" on the ground floor	Room "Palazzo" on the mezzanine floor
9:30 – 11:50	Special Lectures Oral presentation	Break
11:50 - 13:00	Break	Lunch
13:00 - 17:00	Oral presentation (till 16:05)	16:05 - 17:00 Poster Discussion

Poster display: 13:30-17:00

8 September 2017		
	Room "Ambasciatori" on the ground floor	Room "Palazzo" on the mezzanine floor
9:30 - 12:00	Special Lectures Oral presentation	Break
12:00 - 13:00	Break	Lunch
13:00 - 16:40	Oral presentation (till 15:40)	1540 - 16:40 Poster Discussion

Poster display: 13:30-16:40

Oral presentation manner

(Place) Meeting room (Ambasciatori) on the ground floor.

1) At the conference hall, you can use 1 PC with MS Windows 10 and MS-Office.
One screen is available.
Everyone should bring your USB stick .

2) Bring your PowerPoint material with your USB tip at least 30 minutes before your presentation time.

3) Set the USB tip with PC on a presentation desk by yourself at first in your presentation time.

4) A total of your presentation time consists of PC setting (1 min), your oral presentation and discussion (2 min).

For an example: When you have 20 minutes, you should allocate your time as follows.

First 1 minute for PC operation.

Second 17 minutes for your oral presentation.

Last 2 minutes for discussion.

Poster presentation manner

(Place) Room “Palazzo” on the mezzanine floor.

(Poster Display)
Bring pins by yourself.
Your abstract number is shown on your pin board.
Pin your poster material up on your board from 13:30 to your ending time of presentation.
You should withdraw your poster before 17:15. If not, we don’t keep your poster.

(Poster Discussion)

Your discussion time is allocated on 16:00-17:00 Sep 6, on 16:05-17:00 Sep 7 and on 15:40-16:40 Sep 8.

Each presenter should discuss with the attendees beside your poster without any PowerPoint material during the poster discussion time.

(Poster size)
200cm height and 100 cm width

Full paper submission

Any presenter can submit you full paper to our official journal (Journal of Medical Safety; JMS) for a year of 2018.
http://www.iarmm.org/JMS/index.html

JMS2016: http://www.iarmm.org/JMS/JMS2016Cover.pdf
JMS2015: http://www.iarmm.org/JMS/JMS2015Cover.pdf

Submission period: 1st Aug 2017 - 31st Aug 2017

Instructions for authors of full papers:
http://www.iarmm.org/6WCCS/INSTRUCTIONS_FOR_AUTHORS.pdf

Program (Final)

(Utility)

Oral presentation space	: Room "Ambasciatori" on the ground floor
Lunch space	: Room "Palazzo" on the mezzanine floor
Poster presentation space	: Room "Palazzo" on the mezzanine floor

(Official language) English, No translation to other languages.

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SL; Special lecture

Morning 6 September 2017

Room “Ambasciatori” on the ground floor

9:00 Registration desk is open.

[Special Oral Presentation]

10:00-10:30 (SL: NA097) **Automatic Business intelligence tools and tips: How to survive in the new Smart healthcare and its overload of data**

Filippo Bartoccioni, B. Calabrese, G. Orlandi, M. Dubinski, P. Minotti, Y. Akhmetov, K. Pelagagge
Asl Viterbo, Italy

10:30-11:00 (SL: NA090) **Modern Health Education in Clinical Safety Assurance**

Dean & Prof. Bakhtina Irina Sergeevna, & Garderobova L.V.
Saint-Petersburg Postgraduate School of Nursing of the Federal Medical Biological Agency, Russia

11:00-11:30 (SL: NA022) **Improved safety of collection of blood specimens using an interfaced EPIC / Sunquest Laboratory Information System**

Director & Assoc Prof , Milenko Tanasijevic MD, Stacy Melanson MD
Director, Brigham and Women's Hospital, Harvard medical School, USA

[Oral Presentation]

11:30-11:50 (NA098) **Using Mapping to Improve Systems of Clinical Handov**er

Sandy Thomson
GovernancePlus, Australia

11:50-13:00 Lunch at Room “Palazzo”

Afternoon 6 September 2017

Room "Ambasciatori" on the ground floor

[Oral Presentation]

13:00-13:20 (NA085) **Furthering Antibiotic Stewardship through a 'Rolling' Monthly Audit and Teaching**
Mr J A Collins, Dr S. Money-Coomes, Dr Aojula, Dr J Au Yeung, Dr S Khan and Dr R J Parikh
The Royal Oldham Hospital, UK

13:20-13:40 (NA105) **Ethics of Short-term Global Health Operations and Delivery of Care**
Leo Lopez III, MD
Christus Santa Rosa, USA

13:40-14:00 (NA108) **SAPREMO: Safe Ageing - Prevention and Demography at Centre Stage Respecting Polypharmacy**
Dr. med. Ursula Wolf
University Hospital Halle, Martin Luther University Halle-Wittenberg, Germany

14:00-14:20 (NA008) **Medical Acupuncture: How to Improve the Quality Of Life**
Dr. Steven K.H. Aung
University of Alberta, Canada

14:20-15:00 (NA012) **Understanding Serious Adverse Events: A Process to Improve Organizational Culture**
Bonnie Portnoy RN, MJ, CPHRM, CPSO, Senior Director, Risk Management & Patient Safety, Mount Sinai Health System, Vicki Lopachin MD, Chief Medical Officer, Mount Sinai Health System, Rebecca Anderson, Director, Strategic Operations, The Mount Sinai Hospital, USA

15:00-15:20 (NA044) **The Study on Comparison of Perception Differences about Patient Safety Attitude, Surgical Time Out and Factor of Retained Surgical Items between Nurses and Doctors Working in the Operating Room.**
Eunsook Lee(RN, MSN), Eunok Kwon (RN, PhD), Sujeong Jeon (RN)
Seoul National University Hospital, South Korea

15:20-15:40 (NA043) **Global standards and data capture technologies support improvement of clinical safety and the achievement of the five patient rights**
Els van der Wilden-van Lier; Flora Sue
GS1 Global Office, The Netherlands

15:40- 16:00 (NA086) **Implementation of a Management and Reporting Tool as a basis for optimization of Processes and Outcome in 11 Hospitals including Surgical, Orthopaedic and Urological Patients**
Haslinger-R (1), Kamptner-N (1), Halmerbauer-G (1), Ehrenmüller-M (1), Königswieser-T (2), Ausch-C (2)
1. Department of Process Management and Business Intelligence, University of Applied Sciences Upper Austria, Steyr, Austria
2. OÖ. Gesundheits- und Spitals-AG, Linz, Austria

16:00-17:00, 6 September 2017

Room “Palazzo” on the mezzanine floor

[Poster Presentation]

(NA125) **Evaluation of Video Materials Assessing a Family Crisis**
Hisae Nakatani, Akiko Kanefuji,
Hiroshima University, Japan

(NA010) **Count Time Out to prevent count errors**
Hye-young, Kang
Seoul National University Hospital, Korea

(NA147) Attempt at acute care ward to reduce interference with patients’ physical ability
TOSHIKO KOBAYASHI
Toho University, Ohashi Medical Center, Japan

(NA045) **Action of the Disaster Medicine Coordinate Workshops in Japan Held by the "ACT" Institute of Disaster Medicine**
Tadashi Ishii, Kazuma Morino, Yoshikazu Maruyama, Takuya Uozumi, Kuniharu Takahashi
Tohoku University Hospital, Japan

(NA089) **Experiences of Patient Safety Activities of Rapid Response Team for First Year**
Sulhee Kim, Eunjin Yang, Jeoungeun Park, Sangmin Lee, Jinwoo Lee, Hannah Lee, Hyunjoo Lee, Hogeol Ryu, Seungyoung Oh, Sangbae Go
SEOUL NATIONAL UNIVERSITY HOSPITAL, South Korea

(NA078) **Comparison of back pain among physiotherapists and nurses in the Slovenia**
Marcel Duh, Jadrnaka Stričević, David Haložan
Univerisiy of Maribor, Slovenia

(NA009) **Safety management requirements necessary for skilled birth attendance provided by midwifery students, based on the perspective of training instructors**
Kumiko Iwatani 1 , Kyoko Kanamori2, Satomi Yoshida3, Miwa Izuhara4
Kanazawa Medical University, Japan

(NA024) **Safety and Usefulness of Returned Ampule Sorting Machine – toward the Realization of Virtual Cassettes –**
Koichi Takahashi, Kazuko Higuchi, Kazunori Yamaguchi, Nami Mizukawa, Takato Nozaki, Naoki Shinohara, Hiroaki Tanaka, Masato Asakura, Shinji Kosaka, and Hitoshi Houchi
Kagawa University Hospital, Japan

(NA082) **To Improving patient safety and Effective traceability of surgical instruments during sterilization process using GS1 standards**
Shingo Kasamatsu, Yoko Ishimoto, Kazue Suwa, Naomi Emori, Kazufumi Sato, Koichi Uemura, Hironobu Akino,
University of Fukui, Japan

16:00-17:00, 6 September 2017

Room “Palazzo” on the mezzanine floor

[Poster Presentation]

(NA034) **Checking failures and the estimation of risk-taking behaviors: A cross-sectional survey in a university hospital-**

Masako Fujii, Hironobu Akino, Kazuyo Terasaki, Yoshimi Kuwabara, Kimiko Kitahama
University of Fukui, Japan

(NA054) **Simulation Training for Patient Safety in Neurosurgical Emergency - PNLS:Primary Neurosurgical Life Support**

Megumi Takahashi, Masahiro Wakasugi, Hiroshi Okudera, Hisashi Nakashima, Mie Sakamoto, Mayumi Hashimoto, Emiko Asaka
Department of Crisis Medicine and Patient Safety, Graduate School of Medicine, University of Toyama, Japan

(NA065) **Relationship between professional experience as a practicing dietitian and health status or dietary awareness among graduates of a department of food science and nutrition**

Minatsu Kobayashi, Sayo Uesugi, Reiko Hikosaka
Otsuma women's University, Japan

(NA083) **Comparison of Delivery Outcomes between Clinics and Comprehensive Perinatal Care Centers**

kyoko KANAMORI, Kumiko IWATANI, Miwa IZUHARA
Kyoto Koka Women's University, Japan

(NA114) **Developing a ward round checklist to improve patient safety**

Ismail BOZKURT, MD, Chief of Continuous Quality Improvement Department / Medical Director
Burcu BOZKURT, Nursing Manager
Deniz KUCUKLER, Nursing Manager
Fatma KUCUKERENKOY – Manager of Continuous and Quality Improvement Department
Vehbi Koc Foundation American Hospital, Turkey

(NA143) **A descriptive study on medical error incidents including near misses related to insulin injections in a hospital in Japan**

Kumiko Asakawa, Mihoko Kondo,Masako Fujii,Naomi Emori,Tomoko Hasegawa
University of Fukui Hospital, Japan

(NA144) **The Usefulness of “Partnership Nursing System” to prevent Alarm Fatigue in ICU**

Yukie Takayama; Mayumi Tada; Shingo Haneda; Mayumi Miyamae; Shinpei Ohtsuka, Anna Watanabe; Naomi Emori; Tetsuo Fujibayashi; Kazuhiro Kikyo
University of Fukui Hospital, Japan

(NA156) Relationship between postmenopausal symptoms and dietary intake of youth by longitudinal study.

Sayo Uesugi, Minatsu Kobayashi, Reiko Hikosaka
Otsuma Women's University, Japan

Morning 7 September 2017

Room "Ambasciatori" on the ground floor

9:00 Registration desk is open.

[Special Oral Presentation]

9:30-10:00 (SL: NA161) **Strategic communications for medical professionals at the time of crisis: Basics of crisis management and their applications to the cases in healthcare settings**
Hajime SATO
National Institute of Public Health, Japan

10:00-10:30 (SL: NA023) **Cardiac Troponin T could be safely used without CK and/or CKMB to rule out acute myocardial infarction in and emergency ward setting.**
Stacy E.F. Melanson MD PhD, Milenko J. Tanasijevic MD MBA
Brigham and Women's Hospital, Harvard medical School, USA

10:30-11:00 (SL: NA060) **Reducing Nursing Interruptions to Improve Patient Safety**
Prof. Linda McGillis Hall
University of Toronto, Bloomberg Faculty of Nursing, Canada

11:00-11:30 (SL: NA091) **Lessons Learned from a Medication Error: How Safety Culture Mitigates Harm to Both Patients and Clinicians**
Director & Assoc Prof, May C M Pian-Smith, MD, MS
Harvard Medical School, USA

[Oral Presentation]

11:30-11:50 (NA118) **Successful Applications of High Reliability Organization Methods to Improve Patient Safety and Actions Required to Accelerate Progress**
Howard W Bergendahl JD, MS, CPPS
The Bergendahl Institute, LLC, USA

11:50-12:05 (NA116) **CLOPIDOGREL PHARMACOGENETICS: A VALID METHOD TO ASSURE FFECTIVENESS AND SAFETY OF THE ANTIPLATELET THERAPY**
V. Conti, V. Manzo, C. Sellitto, T. Iannaccone, M. Costantino, G. Corbi, P. Malangone, G. Nicolella, G. Accarino, A. Filippelli
University of Salerno, Italy

12:05-13:00 Lunch at Room "Palazzo"

Afternoon 7 September 2017

Room "Ambasciatori" on the ground floor

[Oral Presentation]

13:00-13:20 (NA110) **Evidence under threat: risk communication in an era of alternative facts**
Thomas Rowsell
Uppsala Monitoring Centre, Sweden

13:20-13:40 (NA013) **Accreditation - An Australian Perspective on the Impact of New Mandatory Standards - Opportunities and Challenges for Leaders and Managers**
Sandy Thomson
Quality Systems and Assurance Services Pty Ltd T/A GovernancePlus, Australia

13:40-14:00 (NA119) **Antipsychotic associated metabolic monitoring: How well are we doing it?**
Racha Dabliz, Mental Health Pharmacist, Concord Centre for Mental Health,
Seniha Karacete, Senior Mental Health Pharmacist, Concord Centre for Mental Health,
Angela Meaney, Clinical Nurse Consultant Physical Health & ccCHIP Clinics, Mental Health Service,
Bonnie Tse, Psychiatry Trainee, Concord Centre for Mental Health,
Concord Hospital- Concord Centre for Mental Health, Australia

14:00-14:20 (NA025) **Values, meaning and perspectives for healthcare professionals : impact on patient safety**
Sophie Garcelon
WING SANTE, France

14:20-14:40 (NA073) **Patient Safety and Risk Management: a lesson from the Aerospace industry - IT integration with Electronic Medical Record (EMR)**
DOMENICO MANTOAN, BARBARA CAMERIN, ANDREA BOER, MARINA BRATTINA, LORENZO GUBIAN, FABIO CASSAN, GIACOMO VIGATO
VENETO REGION - HEALTHCARE ORGANIZATION, Italy

14:40-15:00 (NA007) **The Safe Practice of Acupuncture**
Dr. Steven K.H. Aung
University of Alberta, Canada

15:00-15:20 (NA011) **Considering the "Second Victim": ICARE for the Caregiver, Peer to Peer Support**
Bonnie Portnoy, Senior Director, Risk Management & Patient Safety, Mount Sinai Health System (MSHS); Erica Rubinstein MS, Senior Director, Patient Relations & Service Recovery, MSHS; The Mount Sinai Hospital, Vicki Lopachin MD, CMO, USA

Afternoon 7 September 2017

Room “Ambasciatori” on the ground floor

[Oral Presentation]

15:20-15:35 (NA048) **Assess The Culture Of Patient Safety Through Humpty Dumpty Fall Scale (HDFS) Evaluation**
Ola Magdy Torky ,Shaimaa El Meniawy
Children's Cancer Hospital Egypt 57357, Egypt

15:35-15:50 (NA053) **Trial of Exchanging Mini-Medical-Records System Shared between Patient and Doctor**
Kazuhiro Okamura
Okamura Isshindow General Hospital, Japan

15:50-16:05 (NA115) **GENETIC EVENTS IN CHRONIC LYMPHOCYTIC LEUKEMIA**
AURELIAN UDRISTIOIU
Faculty of Medicine, Titu Maiorescu University, Bucharest, Romania

16:05-17:00, 7 September 2017

Room "Palazzo" on the mezzanine floor

[Poster Presentation]

(NA063) **International trades and food risk reports in mass media: the case of BSE**
Hajime SATO
National Institute of Public Health, Japan

(NA004) **Removing biopsy proximity errors through endoscopic biopsy process method change**
Hyojin Shin, Mi-Hyun Yun, Jihee Jung, Sooyeon Huh
Seoul National University Hospital Healthcare System Gangnam Center, South Korea

(NA154) **Are there more incidents in the emergency department during the months of overload? Review through the back to the emergency service (ES).**
Julián Alcaraz Martínez, Mamen Escarbajal Frutos, Pavlo Povzon, Sara Ramos López, Isabel Reina Nicolas, Diana Peñalver Espinosa, Beatriz E Costa Martinez, M Mar Cutillas Perez, Esther García Alfocea, M Jose Carrillo Burgos
Hospital Universitario JM Morales Meseguer, Spain

(NA042) **Development of Pilot Anesthesia Quality Index System in the Standard Surgery Cases**
Yusuke Kasuya, Shiori Sakuma, Makoto Ozaki
Department of Anesthesiology, Tokyo Women's Medical University, Japan

(NA029) **Assessment of school zoonotic diseases awareness program among primary school students in SK Seri Selangor USJ4, Subang Jaya, Selangor, Malaysia**
Shafie, H., Ahmad, N.I., and Ajat, M.
Faculty of Veterinary Medicine, Universiti Putra Malaysia

(NA077) **Comparisons of Emotional Intelligence, Mental Health and Ego-resilience between Mothers of Children/Adolescents with and without Disabilities**
Masumi Omori,Shin-ichi Yoshioka
The University of Shimane Izumo Campus, Japan

(NA079) **The structure of professional confidence of public health nurses**
Tomoko Ogawa, Hisae Nakatani, Akiko Kanefuji, Kiyoka Yamashita
The University of Shimane, Japan

(NA148) **The review of influence on the number of police reporting system by new medical accident investigation system staring from October 2015 in Japan**
Ryoko HATANAKA
The University of Tokyo, Japan

(NA080) **Ergonomic environment of elderly people and encouraging sensory stimulation**
Jadranka Stričević, David Haložan, Dušan Čelan, Milan Brumen, Majda Painkihar, Zmago Turk
University of Maribor, Faculty of health science, Slovenia

16:05-17:00, 7 September 2017

Room "Palazzo" on the mezzanine floor

[Poster Presentation]

(NA072) **Monitoring Critical Values in Primary Care as a Patient Safety Strategy**
Moreno-Campoy EE. Dirección General de Investigación y Gestión del Conocimiento. Consejería de Salud.
Mérida-DelaTorre FJ. Laboratorio Clínico. Área de Gestión Sanitaria Serranía. Servicio Andaluz de Salud
Direccion General de Investigacion y Gestion del Conocimiento. Consejeria de Salud de Andalucia, Spain

(NA094) **Experiences of Patient Safety Activities of Rapid Response Team for First Year**
Sulhee Kim, Eunjin Yang, Jeongeun Park, Sangmin Lee, Jinwoo Lee, Hannah Lee, Hyunjoo Lee, Seungyoung Oh, Hogeol Ryu, Sangbae Go
SEOUL NATIONAL UNIVERSITY HOSPITAL, South Korea

(NA152) **Safety in Medical Environment – Discussion on the Prospective Vulnerability Analysis Results and Risk Management Results**
WEN CHUN TSAI,YA LING CHEN, PEI YING CHEN, YU WEN SHIH, SHU FEN CHOU
Department of Nursing, En Chu Kong Hospital, Taiwan

(NA059) **Communication between nursing students and nurses during practicums**
Yukiko Kai1), Keiko Murakami2), Yuriko Ohkawa1)
School of Nursing, Faculty of Medicine, University of Miyazaki, Japan

(NA081) **Safety assessment of using preliminary formulation for preparing antitumor drugs**
N.Mochizuki, D.Kano, M.Morimoto, N.Yoshino, M.Tanaka, M.Yamaguchi
National Cancer Center Hospital East, Japan

(NA070) **Potential drug therapy issues for the elderly: an insight based on nation-wide prescription audit in primary care**
Khalid Ahmed Jassim Al Khaja, Sindhan Veeramuthu, Reginald P. Sequeira
Arabian Gulf University, Bahrain

(NA087) **The current status of and attitudes towards using a pregnancy-related risk self-assessment scale among Japanese females who gave birth in high-order health care institutions**
Kyoko KANAMORI, Kumiko IWATANI, Miwa IZUHARA
Kyoto Koka Women's University, Japan

(NA139) **Influence of Teamwork Perception and Satisfaction of Intra-organizational Communication on Safety Control**
Kyoung Ja Kim
Hannam University, South Korea

Morning 8 September 2017

Room “Ambasciatori” on the ground floor

9:00 Registration desk is open.

[Oral Presentation]

9:30-10:00 (NA162) **The management of dermal filler complications - Aesthetical Medicine Department of the hospital St. Giovanni Calibita - Fatebenefratelli in Rome**
Gloria Trocchi, Emanuele Bartoletti
Aesthetical Medicine Department of the hospital St. Giovanni Calibita - Fatebenefratelli in Rome

[Special Oral Presentation]

10:00-10:30 (SL: NA075) **The Role of Nurse Leaders in the Promoting the Safe Integration of Internationally Educated Nurses into Canadian Hospitals**
Prof. Linda McGillis Hall, PhD, FAAN, FCAHS
University of Toronto, Canada

[Oral Presentation]

10:30-10:50 (NA071) **THE USE OF MEDICAL SIMULATORS MAY LEAD TO A SIGNIFICANT REDUCTION IN HEALTH CARE COSTS**
G. Halmerbauer1, N. Kamptner, A. Schrempf, C. Ausch
University of Applied Sciences, AUSTRIA

10:50-11:10 (NA088) **An application of classification methods on clinical data for retrospective detection of patients with complications**
R. Haslinger (1), G. Halmerbauer(1), H. Wagner(2), C. Ausch(3)*
(1)Department of Process Management and Business Intelligence, University of Applied Sciences Upper Austria, Steyr
(2)Department of Applied Statistics , Johannes Kepler University, 3OÖ. Gesundheits- und Spitals-AG, Linz, Austria

11:10 –11:30 (NA015) **Clinical Leadership in Establishing General Practitioner Accreditation for Minor Surgery: A National Pilot Study**
Dr Ailís ní Riain, Dr Claire Collins, Dr Tony O'Sullivan
Irish College of General Practitioners, Ireland

11:30-11:50 (NA100) **Team Briefing - Changing the Focus of Surgical Safety Checklists**
Kristine Wyatt
Kyneton District Health, Australia

11:50-13:00 Lunch at Room “Palazzo”

Afternoon 8 September 2017

Room "Ambasciatori" on the ground floor

[Oral Presentation]

13:00-13:20 (NA003) **Integrating Nursing Informatics to Improve Patient-Centered Care**
Pi-Chi Wu
Department of Nursing, Chiayi Chang Gung Memorial Hospital, Taiwan

13:20-13:40 (NA005) **GENETIC EVENTS IN CHRONIC LYMPHOCYTIC LEUKEMIA**
Aurelian Udristioiu, Manole Cojocaru
Emergency County Hospital & , Faculty of Medicine, Titu Maiorescu University, Romania

13:40-14:00 (NA049) **Utilization Management Of Platelets Units Using Lean Six Sigma Methodology**
ola magdy abdel hameed torky
Children's Cancer Hospital Egypt 57357, Egypt

14:00-14:20 (NA041) **Preventing and managing hospital acquired pressure ulcers**
Hany Mohamed, Mohamed kheder, sayda medany, ayman Mohamed and wesal skaker
Children's Cancer Hospital Egypt 57357, Egypt

14:20-14:40 (NA153) **The Enhancement of ER Workplace Safety as to Reduce the Turnover Rate of the Nursing Staff**
WEN CHUN TSAI, YU WEN SHIH, YU HUA CHOU
Department of Nursing, En Chu Kong Hospital, Taiwan

14:40-15:00 (NA036) **The usefulness of After Action Review system to improve the quality of debriefing in medical system**
Hitoshi Yanaihara, Naoto Okada, Satoru Utsunomiya, Toshiyuki Narumi, Kanji Kabasawa, Sakae Otani, Masayasu Aoki Yuichiro Yana, Eiji Morita, Yasuto Omura, Hidetomo Nakamoto
Saitama Medical University, Japan

15:00-15:20 (NA064) **The relationship between working hours and dietary habit and weight gain during the pregnancy period**
Eri Abe, Minatsu Kobayashi, Kohei Ogawa, Katsunori Cha, Naho Morisaki, Takeo Fujiwara
Ohtsuma Women's University Japan

15:20-15:40 (NA017) **Development the Patients Safety and Quality Management Feedback Support System for the purpose of reduction in task load of Patients Safety Manager**s
Tatsuya Kitano
Seijoh University, Health Care Management Course,Faculty of Business Administration/Graduate School of Health Care Studies,Patients Safety & Quality Management , Japan

15:40-16:40, 8 September 2017

Room “Palazzo” on the mezzanine floor

[Poster Presentation]

(NA050) **Utilization Management Of Platelets Units Using Lean Six Sigma Methodology**
Ola Magdy Torky ,Shaimaa El Meniawy
Children's Cancer Hospital Egypt 57357, Egypt

(NA051) **Assess The Culture Of Patient Safety Through Humpty Dumpty Fall Scale (HDFS) Evaluation**
Ola Magdy Torky ,Shaimaa El Meniawy
Children's Cancer Hospital Egypt 57357, Egypt

(NA061) **Factors analysis of poor healing wound in negative pressure wound therapy**
YEN-HSI, LIN, TING-TING, CHENG, JIUN-LING,WANG
National Cheng kung University Hospital , Taiwan

(NA062) **Evaluation of multidisciplinary management care involved in diabetic wound**
YEN-HSI, LIN,, JING-YI, LIN , JIUN-LING, WANG
National Cheng kung University Hospital , Taiwan

(NA067) **Development and validation of a trigger tool to identify adverse events and no-harm incidents in home healthcare**
Marléne Lindblad, Schildmeijer Kristina, Nilsson Lena, Ekstedt Mirjam, Unbeck Maria
Royal Institute of Technology, School of Technology and Health, Stockholm, Sweden

(NA157) **Stercoral colitis**
Lee, Mei-Lin, Tu Chu-Li, Yu-Feng Tian
Chi-mei Hospital, Tainan, Taiwan

(NA159) **Self-expandable metal stent(SEMS) Enhance The Patient Preoperative Life Quality**
Tu Chu-Li
Chi-mei Hospital, Tainan, Taiwan

(NA117) **Falling in Hospitalized Patients Under the Influence of a Soporific – Analysis of Public Adverse Event Reports on the Web**
Taiko TERASHIMA; Lecturer; Japanese Red Cross Hokkaido College of Nursing, Hokkaido, Kitami, Japan
Akiko Hiyama; Lecturer; Sapporo City University, Sapporo, Hokkaido, Japan
Junichi TANEMOTO; Assistant professor; Japanese Red Cross Hokkaido College of Nursing, Kitami, Hokkaido, Japan
Sadako Yoshimura; Emeritus professor; Faculty of Health Sciences, Hokkaido University, Sapporo, Hokkaido, Japan

15:40-16:40, 8 September 2017

Room “Palazzo” on the mezzanine floor

[Poster Presentation]

(NA033) **Implementation of a patient education multimedia tool to enrich patient knowledge about their planned anesthesia care in advance of surgery**
Kyan C. Safavi MD MBA, Yuri Chaves-Martins MD, Shu Lu MD, Emily Naoum MD, Gabrielle Paoletti MD, Katarina Ruscic MD PhD, Lisa Warren MD, Lisa Leffert MD
Massachusetts General Hospital, USA

(NA130) **Working stress and coping strategies among intensive care nurses**
Shu-Ching Lin, Shu-Ming Chen
Chi Mei Medical Center, Taiwan

(NA069) **Characteristics of psychosocial support for supporters in disaster relief**
Chikako Itagaki, Tadashi Ishii
Japanese Red Cross Medical Center, Japan

(NA076) **Evaluation of inter-rater reliability and accuracy of the Fall Risk Behavior Assessment Tool (FRBA-Tool) for prediction of the risk of fall**
Akiko Hiyama, Keiko Nakamura
Faculty of Nursing, Sapporo City University, Japan

(NA128) **Rapid communication with patient side to share the truth**
Yukio Seki, Miho Kinoshita, Junichi Mizuno, Norie Tsuboi, Mitsuyo Ohno, Masaru Inoko, Yumiko Kose
Japanese Red Cross Nagoya Daini Hospital, Japan

(NA074) **Actual Use of Non-Technical Skills Related to Intravenous Drip Management by First-year Nurses in Japan**
Saeko KINUGAWA, Noriko KUROSAWA
Division of Nursing faculty of Nursing, Tokyo Healthcare University, Japan

(NA124) **Introduction of TeamSTEPPS training for education of medical school 4th grade**
Hiroshi OKUDERA, M.D.,Ph.D., Hisashi NAGASHIMA, M.D., Ph.D.
Masahiro Wakasugi, M.D., Ph.D. ,Yoko YAMAMOTO, R.N., M.Ms.
Etsuko NOGAMI, R.N., M.Ns.
Toyama University Hospital, Japan

(NA145) **Influence of our new nursing system called the Partnership Nursing System: PNS on medical safety and patients’ satisfactions**
Naomi Emori , Miho Murata , Yukie Takayama , Kumiko Asakawa , Kazue Suwa , Tomoko Hasegawa
University of Fukui Hospital, Japan

Abstract

6 Sep 2017 Oral

6 Sep 2017, 10:00-10:30 (SL: NA097) Oral

Automatic Business intelligence tools and tips: How to survive in the new Smart healthcare and its overload of data

Filippo Bartoccioni, B. Calabrese, G. Orlandi, M. Dubinski, P. Minotti, Y. Akhmetov, K. Pelagagge
Asl Viterbo, Italy

Introduction
Nowadays more and more often we see health smart devices connected to internet. All these data are stored somewhere in the cloud and are growing more and more due to high increasing number devices and applications that always measure multiple parameters and with increasing frequency.
This will create an overload of data to analyze, but the doctor or the institution that take care of the patient does not have the time to analyze it manually. They need an automatic way to monitor, analyze and follow up in time the patient data. Data Analysis and business intelligence software are very expensive.
Aim
The aim is was to build a business analysis using free software tools to personalize our business intelligence.
Methods
We investigated the actual market to choose advanced free tools, such as add on and plug in, and we tried to apply to healthcare unit personalized business intelligence but with the idea to extend these tools to patient care business intelligence.
Results
We were able to build automatic month reports using free plug in and free online platform that permit to the General Director to manage an entire province health care without additional costs. The smart healthcare is going to produce huge quantity of data but without a business intelligence system nobody will be able to read it. This is making smart healthcare less efficient and less useful. Thanks to the knowledge of integration with free service and software, the smart healthcare can really accelerate its diffusion.

6 Sep 2017, 10:30-11:00 (SL: NA090) Oral

Modern Health Education in Clinical Safety Assurance

Dean & Prof. Bakhtina Irina Sergeevna, & Garderobova L.V.
Saint-Petersburg Postgraduate School of Nursing of the Federal Medical Biological Agency, Russia

Clinical safety is a basic component of healthcare quality. At present, virtually safe diagnostic and therapeutic modalities (in the context of any patient) as well as methods of preventing diseases of various etiology are not available whereas such practices in relation to patients themselves and healthcare providers become increasingly aggressive, which may cause sequalae of healthcare-associated activities. Continuous medical education with an emphasis on risk management in healthcare becomes prerequisite for safety assurance of healthcare services.
The St. Petersburg Postgraduate School of Nursing has the experience in educating nurses for clinical practice gained over the past 25 years. Our curricula are practice-oriented, based on the modular principle with the inclusion of teaching modules in all aspects of healthcare services' safety (legal, technological, infectious, behavioral, informational).
Today, significant resources are getting involved in assuring the quality of training of healthcare providers by introducing active teaching techniques and innovative educational approaches – simulation training and e-learning. At our simulation center, healthcare professionals are trained in clinical safety assurance in the simulation trainings with the use of simulation equipment with varying levels of realism. Advantages of such trainings are as follows: learning and gaining clinical experience under the circumstance of clinical simulation without subjecting the patient to a risk; developing skills in treating rare and life-threatening conditions; objective evaluation of established competences; interactive skill drills within a multidisciplinary team. The experience of modern systematic training of healthcare providers that is in demand in all country's clinical settings has been presented at international scientific-practical events.

6 Sep 2017, 11:00-11:30 (SL: NA022) Oral

Improved safety of collection of blood specimens using an interfaced EPIC / Sunquest Laboratory Information System

Director & Assoc Prof , Milenko Tanasijevic MD, Stacy Melanson MD
Director, Brigham and Women's Hospital, Harvard medical School, USA

We have implemented a fully interfaced system, linking the physician order entry module of our electronic health record with the laboratory information system and two versions of a positive patient identification system. In addition of positive patient identification, the system provides an information about the appropriate number and types of blood collection tubes. It also enables specimen label printing at the patients bedside. Its implementation resulted in a significant decrease of specimen collection errors at our institution.

6 Sep 2017, 11:30-11:50 (NA098) Oral

Using Mapping to Improve Systems of Clinical Handover

Sandy Thomson
GovernancePlus, Australia

In Australia a mandatory accreditation standard on Clinical Handover was introduced in 2012. This was in response to a more detailed understanding of the patient safety risks associated with poor clinical handover. The most favored tools used are ISBAR or ISoBAR which are well known internationally.
Many organisations have struggled to embed structured clinical handover systems in clinical areas particularly wards where the expectation is that this occurs at the bedside and with involvement of patients and or carers in the process. Effective and efficient clinical handover between medical officers and departments still remains problematic. This is compounded by the number of interactions with departments that a patient may experience as part of their patient journey.

Our presurvey data from 2012 -2017 indicates that on average 51% of participating organisations were unable to meet the 9 core mandatory actions for Clinical Handover.

Our work has also identified a poor understanding of handover requirements in other areas such as ambulance to Emergency, Emergency to wards, wards to theatres or for diagnostic testing.

To improve systems of handover and patient safety outcomes a handover mapping tool and workshop is being used to facilitate a shared understanding of handover issues in clinical areas.

This process identifies what is working well or are not in place in a visual format which then facilitates a more structured and collaborative approach to address gaps. Handover incidents can also be included to demonstrate the impacts on patients.

Outcomes are improved patient safety outcomes and improved understanding of handover requirements

6 Sep 2017, 13:00-13:20 (NA085) Oral

Furthering Antibiotic Stewardship through a 'Rolling' Monthly Audit and Teaching

Mr J A Collins, Dr S. Money-Coomes, Dr Aojula, Dr J Au Yeung, Dr S Khan and Dr R J Parikh
The Royal Oldham Hospital, UK

Leading Effective Change'

Aim:
Antibiotic resistance is one of the greatest challenges in modern healthcare. Management of resistant organisms is complicated by the production of few new antibiotics since the developments of the 20th century. We must therefore sensibly prescribe and protect current medications.
Previously we described our work to improve antibiotic prescribing by empowering junior doctors to perform their own monthly audit of prescriptions. We have now extended our work to create a rolling monthly audit. The junior team audit their own prescribing and in doing so, learn to steward the use of antibiotics.

Methods:
A rolling audit was performed in November, January and March that examined the notes and prescriptions of ward patients. These were checked for evidence of indication, review date, adherence to policy, correlation to cultures, documented allergy status and concurrent PPI usage.

Outcomes/Results:
The numbers of patients on antibiotics varied. All patients had documented indications and allergy status in each audit. There was variability in compliance with policy, review, correlation to cultures and PPI prescriptions over the 3 months.

Conclusion:
Extending our work to cover 2 rotations of doctors provided new challenges in delivering teaching to new starters and engaging staff to participate in the audit. However, it is of great importance that the junior members of the team prescribe conscientiously in order to steward the use of antibiotics effectively. Combining a rolling-audit and teaching of the UK NICE guidance helps doctors to improve their prescribing and reinforce their knowledge to improve care.

6 Sep 2017, 13:20-13:40 (NA105) Oral

thics of Short-term Global Health Operations and Delivery of Care

Leo Lopez III, MD
Christus Santa Rosa, USA

An estimated 29% of U.S. medical students experience or rotate in a global health trip or elective during their training. 1.6 million volunteer tourists spend $2 billion annually on short term global health trips. Aside from cost, questions regarding ethics, quality, and access invariably arise. Short term global health operations are often criticized for being self-serving, ineffective, and lacking appropriate standards. At present, there is no governing body to regulate these operations. My family medicine residency program offers the opportunity to participate in global health service operations. The purpose of this presentation is to examine the delivery of care of our team and analyze our operation through the lens of the general principles of global health ethics. Through this self-evaluation, we will improve quality, and be in a more ideal position to protect the vulnerable populations we serve.

6 Sep 2017, 13:40-14:00 (NA108) Oral

SAPREMO: Safe Ageing - Prevention and Demography at Centre Stage Respecting Polypharmacy

Dr. med. Ursula Wolf
University Hospital Halle, Martin Luther University Halle-Wittenberg, Germany

Demographic ageing and working as 1. general practioner, 2. pharmacist or 3. nursery means being involved in management of polypharmacy in geriatric patients. Within this vulnerable patient group drug safety requires more educated and interprofessional engagement of all health professionals.

To obtain intense and precise cooperation, communication and networking with regard to polypharmacy SAPREMO was designed addressing all three health professions equally. Operating as a team is the fundamental idea of this interprofessional project involving the three groups treating the same patient at different yet confluencing stages. The innovative aspect is to identify new symptoms that might result from drug effects or side effects and adapt as early as possible. Interprofessional round table educating workshops as well as interprofessional educative lectures are implemented throughout the German federal state Saxony Anhalt as the project´s baseline. SAPREMO aims to leave the most critically universalized step up treatment with further drug therapy to cope with drug induced new symptoms as alarmingly observed by the author´s more than 8680 detailed medication reviews of geriatric patients in traumatology, intensive care units as well as nursing homes. In consequence the worldwide public health‘s challenge esp. concerning manifestation of cognitive dysfunction and falls and fractures in the elderly people imperatively requires prevention instead of the overall and most expensive attempt to iron out manifestations of undetected because disregarded drug related problems.

Cooperation partners are the Medical Council, Pharmacists‘ Chamber, General Practioners‘ Association and Association of Statutory Health Insurance Saxony Anhalt. The challenging project has started with great resonance striking a significant chord and is supported by the Robert Bosch Foundation.

6 Sep 2017, 14:00-14:20 (NA008) Oral

edical Acupuncture: How to Improve the Quality Of Life

Dr. Steven K.H. Aung
University of Alberta, Canada

Medical acupuncture is not only useful for pain control but also for balancing the flow of energy and harmonizing organ systems. Therefore acupuncture is not limited to localized disorders but also for systemic diseases. Medical acupuncture is an art and science. It involves the arts of healing and the science of balancing the body. In addition it is very useful for stimulating the body's immune system to function better for preventing infections and excessive heat, wind, cold, or other issues. It is also useful for mental disorders such depression, sadness, anxiety, worry, fear, or others. Medical acupuncture can also open up inner and outer emotional gates so these can be ventilated. It may also be used for treating spiritual components of disorders or diseases. In chronic illnesses medical acupuncture may be used to treat physical, mental, and spiritual components. Often chronic illness requires that spiritual aspects be diagnosed and treated. Medical acupuncture may also re-align vital energy, which can improve a person's body, mind, and spirit. The chakras of the energy centre can be treated effectively and help improve the quality of life of many patients. Balancing and harmonizing organ and meridian systems contributes to wellness. Medical acupuncture can play an important part in the quality of life.

6 Sep 2017, 14:20-15:00 (NA012) Oral

nderstanding Serious Adverse Events: A Process to Improve Organizational Culture

Bonnie Portnoy RN, MJ, CPHRM, CPSO, Senior Director, Risk Management & Patient Safety, Mount Sinai Health System, Vicki Lopachin MD, Chief Medical Officer, Mount Sinai Health System, Rebecca Anderson, Director, Strategic Operations, The Mount Sinai Hospital, USA

The Mount Sinai Hospital has developed a structured approach to responding to Serious Adverse Events (SAE) that provides a mechanism for organizational culture change. Since early 2014, the new SAE response process has been instrumental in furthering the hospital's ability to create an organizational culture that is responsive to patient and staff needs and exemplifies the delivery of safe, high quality care. The process is implemented when any event or near miss occurs, not just when an investigation is required for reporting. Creating a structure to address SAEs that has the right people involved and is done in a system-focused way has allowed for the meaningful design and execution of corrective action plans (CAP). Critical elements of the new process include an immediate huddle with a formal debriefing within 72 hours of the event, Root Cause Analysis (RCA) using performance improvement (PI) tools and defined roles, CAP development and implementation based specifically on the RCA findings, and strong senior leadership involvement. Using a systematic, human factors approach allows for organization-wide performance improvement and learning. The strategic vision behind the new response process focuses on systemic issues and pushing the organization to clinical and operational excellence. Ultimately, a well-designed SAE process can empower leaders to transform an organizational culture and improve patient outcomes. Training, standardization and senior leadership endorsement have been leveraged at The Mount Sinai Hospital to create an environment where all staff can feel comfortable reporting events and a Just Culture can be cultivated.

6 Sep 2017, 15:00-15:20 (NA044) Oral

The Study on Comparison of Perception Differences about Patient Safety Attitude, Surgical Time Out and Factor of Retained Surgical Items between Nurses and Doctors Working in the Operating Room.

Eunsook Lee(RN, MSN), Eunok Kwon (RN, PhD), Sujeong Jeon (RN)
Seoul National University Hospital, South Korea

Purpose: The purposes of this study are to investigate and compare the attitude of patient safety, the performance of the surgical time out and the factors of retained surgical items among nurses and doctors working in the operating rooms.
Methods: Nurses, surgeons and anaesthesiologists participated in this study from August 1st, 2015yr to February 5th, 2016yr. 171 cases were analysed and the questionnaire consists of Safety Attitude Questionnaire, surgical time out and factor of retained surgical items .
Results: Differences exist among teamwork climate, working conditions, perception of management and stress recognition between nurses and doctors ($p<.01$). The performance of the surgical time out nurses showed higher score in way of counting, while doctors showed higher scores in time out procedure. Nurses perceived doctors didn't wait in time out procedure but doctors perceived themselves very cooperative. More experienced staffs showed high scores than younger staffs in operating room. The patient safety attitude, surgical time out and retained surgical items are correlated each other.
Conclusions: The attitude of patient safety, the performance of the surgical time out and the factors of retained surgical items are correlated with each other. Nurses and Doctors have a different perception in terms of the attitude of patient safety, the performance of the surgical time out and the factors of retained surgical items. Perception differences among doctors and nurses needs to be more analysed for the patient experiencing surgery safely.

6 Sep 2017, 15:20-15:40 (NA043) Oral

lobal standards and data capture technologies support improvement of clinical safety and the achievement of the five patient rights

Els van der Wilden-van Lier; Flora Sue
GS1 Global Office, The Netherlands

In several sectors Global automatic identification and Data Capture (AIDC) standards have played a crucial role in establishing a safe and secure supply chain with high quality. These AIDC standards are fully applicable in healthcare. In the recent 20 years thousands of hospitals around the world have implemented GS1 standards in different areas of work to ensure patient safety next to reaching supply chain benefits. The right use of these standards also facilitates reducing threats on patient safety from counterfeit medical supplies. Still little research has been done concerning the international perspective of global standards and clinical safety.
This study examined the AIDC implementations in 18 hospitals in different regions (Europe, Asia, South America and North America). After adopting global AIDC standards for pharmaceuticals, medical devices, patients and locations, both clinical and supply chain benefits were reported.
The most reported clinical benefits are patient safety / better quality of care; data recorded and updated accurately and immediately; time saving / more time for patients; improved work accuracy; efficiency and fluency; avoided / reduced errors; enabled / improved traceability and recall.
Global standards implementation in hospitals were associated with higher patient safety, which was observed in 18 hospitals from 12 countries. Flexibility is required in adapting global standards to local needs and constraints. In this study factors conducive to global standards implementation success in achieving efficiency objectives have been identified.

6 Sep 2017, 15:40- 16:00 (NA086) Oral

mplementation of a Management and Reporting Tool as a basis for optimization of Processes and Outcome in 11 Hospitals including Surgical, Orthopaedic and Urological Patients

Haslinger-R (1), Kamptner-N (1), Halmerbauer-G (1), Ehrenmüller-M (1), Königswieser-T (2), Ausch-C (2)
1. Department of Process Management and Business Intelligence, University of Applied Sciences Upper Austria, Steyr, Austria
2. OÖ. Gesundheits- und Spitals-AG, Linz, Austria

Background:
Starting in 2009, an effort to improve clinical outcomes and reduce costs in surgical procedures was initiated by the University of Applied Sciences in Upper Austria. Since 2015, eleven hospitals have taken part in this program, adding up to more than 75 % of beds in the county. As role models, systems were chosen which had been initiated by Intermountain Healthcare or the National Surgical Quality Improvement Program (NSQIP). The primary aim of this program was to introduce value-based care in participating hospitals and by doing so to optimize processes of care.

Methods:
In a multi enterprise effort to improve clinical outcomes and reduce costs, a management and reporting tool, "Rosetta Medical", was developed which allows clinicians and managers to analyze actual costs and outcomes at the level of individual encounters and by department, diagnosis, and procedure. Data from hospital data bases (services provided for the patients, length of stay (LOS)) was combined with data (55 predefined pre-operative risk factors and complications/mortality) collected by specially trained nurses. To ensure high data quality and comparable data, records were standardized by different systematized mapping catalogues for medicine and pricing catalogues. Additionally physicians were included in the data collection process. Results are compared on a risk-adjusted basis between the hospitals using statistical methods.

Results:
For the first time, it was possible to compare processes, outcome and costs periodically on a risk- adjusted basis in Austrian hospitals of varying sizes. Key figures are used as basis for care process and outcome optimization.

Conclusion:
For the participating hospitals "Rosetta-Medical" provides a unique opportunity to compare their work on a fair and transparent basis and enables collaborative initiatives to adopt evidence-based best practices.

Abstract

6 Sep 2017 Poster

6 Sep 2017, 16:00-17:00 (NA125) Poster

Evaluation of Video Materials Assessing a Family Crisis

Hisae Nakatani, Akiko Kanefuji,
Hiroshima University, Japan

Purpose;
Public health nurses (PHNs) have a role of family nursing for families with composite health problems. We created video for PHNs to learn family nursing. The purpose of this study was to clarify the effectiveness of the video material to learn about family assessment.
Method;
The video material was based on a case of a family of five; a 3-year-old girl, father, mother (a Chinese resident of Japan), and grandparents. The intake provided by a public health nurse was at the daughter's 3-year-old checkup, in which she was suspected to have delayed language development. At a home visit after the checkup, the public health nurse found that her father was hospitalized for alcoholism and her mother was isolated in her family and community. The video was uploaded on our homepage for e-Learning. Then questionnaire survey of 14 anonymous PHNs who took part in the e-Learning was conducted. We asked three questions to investigate of the family crisis from the video material.
Q1: Were you able to observe in individuals on the video?
Q2: Did you successfully assessment from the video?
Q3: Do you think this e-Learning which includes advantages of using video of the case?
Result & conclusion;
At least 50% of respondents recognized that using online material was an effective method for observation and assessment of individuals. Positive responses did not reach 50% on video-based case studies. These results suggested that e-Learning functions are important.

6 Sep 2017, 16:00-17:00 (NA010) Poster

Count Time Out to prevent count errors

Hye-young, Kang
Seoul National University Hospital, Korea

1. Introduction
As known from many researches, effective communication is the key point for patient safety including creating a system that removes potential dangers and decreases surgical errors.
Meanwhile, It was found that due to heavy pressures from large number of operation performed daily (more than 130 cases per day in Seoul National University Hospital in Korea) faced by the surgeon, nurses are pushed to count the items used in a hurry and held the main responsibility of implementing and maintaining surgical counts.
Increasing types and number of surgical instruments used during surgeries proved to be another burdensome factor especially for inexperienced nurses or those working in an unfamiliar area of surgery.
For this reason, it must be stressed that both the surgeon and the nurse are ultimately responsible for effectively carrying out surgical counts. In order to promote cooperation between surgeons and nurses and to remove inhibiting factors, the establishment of an effective communication system such as Count time out must take place

2. Method
1) Request for cooperation with the medical departments through the OR management team
2) Revise Count time-out scenario
3) Count time-out promotional campaign and “King of Count time-out” contest
4) Offer safety posters for count time-out awareness
5) Promote knowledge of count time-out
6) Strengthen computerized records based on count error prevention

3. Result & Conclusion
Although initially, medical personnel were unfamiliar with the term ""count time-out” and had resistance, they familiarized themselves with the practice and accepted ""count time-out"" as part of their surgical routine. Seeing increased implementation rate of ""count time-out”, it contributed to fixate culture of safety successfully.

6 Sep 2017, 16:00-17:00 (NA147) Poster

Attempt at acute care ward to reduce interference with patients' physical ability

TOSHIKO KOBAYASHI
Toho University, Ohashi Medical Center, Japan

Purpose:
This research focused on the attempt to reduce interference with the physical ability of patients at the A acute care ward of the educational hospital while ensuring their safety at the same time. The following is the report on the research.

Methodology:
The researcher interviewed the nurse administrator (hereinafter referred to as "HN" meaning "head nurse") and the certified nurse in gerontological nursing (hereinafter referred to as "RN" meaning "resource nurse"), who both reached out to their staff to avoid intervention to the physical ability of patients at the A ward if at all possible over the past two years. Citing practice cases, the interviews clarified how the staff changed their attitude.

Results:
One HN and one RN working for the A ward cooperated with the research. Their years of experience were between 15 and 20 years.

Both of them were educating the ward staff persistently at conferences and in the realistic medical setting to avoid interference with patients' physical ability. They were advising the staff firstly to encourage patients to recognize their actual status, and secondly to secure the healthy environment for the patients. The staff learned to focus on the state of patients and empathize with the distinctive features of elderly patients. As a result, the staff became able to refrain from intervention to patients' physical ability and look after individual patients in their best interest.

Observations;

The HN and the RN at the A ward relentlessly coordinated with all staff out of their eagerness to get them to learn to respect the dignity of the elderly because, as human beings, patients and the staff were all the same. The two leading nurses treated each elderly patient as the one and only individual and instructed their staff to respect the personality of each patient. As a result, the ward could reduce the patients' anxiety and ensure their safety.

6 Sep 2017, 16:00-17:00 (NA045) Poster

Action of the Disaster Medicine Coordinate Workshops in Japan Held by the "ACT" Institute of Disaster Medicine

Tadashi Ishii, Kazuma Morino, Yoshikazu Maruyama, Takuya Uozumi, Kuniharu Takahashi
Tohoku University Hospital, Japan

Here, we introduce the Disaster Medicine Coordinate Workshops held by the “ACT” Institute of Disaster Medicine (AIDM). On March 11, 2011, the Great East Japan Earthquake struck the northeastern coast of Japan with a magnitude of nine. The death toll reached 15,892 and 2,576 people were reported missing. The city of Ishinomaki was affected most severely with 5,385 dead and 710 people missing.
In order to efficiently and effectively utilize medical resources with a limited number of relief teams, we launched the Ishinomaki Zone Joint Relief Team, which centralized medical support and relief work within the Ishinomaki Medical Zone, on March 20, 2011. We divided the Ishinomaki Medical Zone into 14 areas and allocated relief teams to each area as required. We performed continuous assessments on more than 300 evacuation shelters, evaluated their environment, and implemented measures accordingly. A total of 955 registered teams joined the relief work.
To deal with the next disaster, we established AIDM as a nonprofit organization on March 11, 2012. Since one of our objectives was to teach coordination skills including reflective points through workshops, as of December 31, 2016, we held workshops for local government disaster medical coordinators and Head Quarters personnel 61 times to teach coordination skills, such as how to organize/manage dispatched relief teams and provide not only medical treatment based on comprehensive collection, administration and analysis of information, as well as addressing healthcare management needs.

6 Sep 2017, 16:00-17:00 (NA089) Poster

Experiences of Patient Safety Activities of Rapid Response Team for First Year

Sulhee Kim, Eunjin Yang, Jeoungeun Park, Sangmin Lee, Jinwoo Lee, Hannah Lee, Hyunjoo Lee, Hogeol Ryu, Seungyoung Oh, Sangbae Go
SEOUL NATIONAL UNIVERSITY HOSPITAL, South Korea

[Objectives]
Rapid response system is the patient safety system designed to predict deterioration of physical conditions and prevent unscheduled admission to intensive care units (ICU) and occurrence of cardiopulmonary resuscitation (CPR) by taking immediate care of those patients. In August 2015, this hospital launched the Rapid Response Team (RRT) for 21 surgical wards. This study aimed to compare the activities and performances of RRT between the former 6 months (hereinafter “A Period”) and the latter 6 months (hereinafter “B Period”) during first year.

[Methods]
This hospital is a tertiary hospital containing 1,786 beds. The RRT is a multi-disciplinary team and runs from 7:00 AM to 7:00 PM on weekdays.
The RRT is activated in either way when bedside medical staff call for or by proactive rounding conducted especially for high risk patients in wards.
In weekly team meetings, team members tried to judge whether it was possible to prevent CPR occurring in surgical wards. For one year, the team compared occurrence rate of preventable CPR and unscheduled admission to ICU between A Period and B Period.

[Results]
The total number of cases of RRT activation was 675 (318 in A Period and 357 in B Period)
Unscheduled admission to ICU was 5.87 cases per 1,000 admissions in A Period, whereas 6.26 cases in B Period, and the ICU length of stay (LOS) was 7.65 days in A Period, whereas 5.54 days in B Period.
Proportion of preventable CPR was 73% (8/11) in A Period, whereas 50% (3/6) in B Period.

[Conclusion]
Compared to A Period which can be described as the period of public relations and settlement of RRT, LOS and proportion of preventable CPR was reduced by 27.6% and 23% respectively during B Period which can be described as mature period of RRT. From these results, RRT may contribute to the promotion of patient safety.

6 Sep 2017, 16:00-17:00 (NA078) Poster

Comparison of back pain among physiotherapists and nurses in the Slovenia

Marcel Duh, Jadrnaka Stričević, David Haložan
Univerisiy of Maribor, Slovenia

Back pain commonly occurs among health care workers, especially among physiotherapists and nurses. 90 health care workers (45 physical therapists and 45 nurses) from various healthcare institutions from Maribor, Slovenia took part in the research. We found no statistically significant difference in the occurrence of back pain between the two professions in the year leading up to study (p=0,517). We found that back pain is more frequent among health care professionals employed in institutions with immobile patients (p=0,03). Representatives of both professions with more years of service also had more back pain than those with less years of service (p=0,008). We noticed that ergonomic knowledge didn`t affect back pain occurrence (p>0,05). Representatives of both professions are equally exposed to manifestation of back pain. As expected, health care professionals who work with immobile patients are more prone to back pain. Participants with more years of service had more back pain. We found that ergonomic knowledge didn`t affect back pain occurrence so we believe that only amelioration of this problem lies in the use of assistive devices for patient transfers. We also believe, that big role in solving back pain among health care workers have educational institutions who should educate students how to properly transfer patients (manually and mechanically). Health institutions should also invest in assistive devices to relieve health care workers.
Keywords: back pain, physiotherapists, nurse, ergonomy, ergonomical assistive device.

6 Sep 2017, 16:00-17:00 (NA009) Poster

Safety management requirements necessary for skilled birth attendance provided by midwifery students, based on the perspective of training instructors

Kumiko Iwatani 1 , Kyoko Kanamori2, Satomi Yoshida3, Miwa Izuhara4
Kanazawa Medical University, Japan

Background: With regard to midwifery education in Japan, there are no standardized criteria for evaluating safety management of birth attendance. The development of such criteria that can be used in both educational and clinical settings will contribute to establishing standardized education.
Objective: To identify safety management requirements necessary for birth attendance provided by midwifery students, based on the perspective of training instructors in Japan.
Methods: Semi-structured interviews were conducted involving 10 training instructors of facilities that offer training to midwifery students, and the obtained data were analyzed using a qualitative and descriptive approach. The interview focused on items that are necessary for safety management of birth attendance. Berelson's content analysis (1957) was used to analyze data. This study was approved by the ethical review committee of the research director's university.
Results: As safety management requirements necessary for birth attendance provided by midwifery students, the following 7 categories were extracted: "mastering birth attendant skills", "having basic knowledge of birth attendance", "having the ability to assess information to judge and predict situations", "being able to report, contact, and consult", "being able to act safely using one's personal traits", "being able to learn proactively", and "learning safety management step by step".
Conclusions: The 7 categories were identified as safety management requirements necessary for birth attendance. In the future, views of people involved in education will be investigated, and, based on the results, we will develop standardized evaluation criteria for safety management of birth attendance applicable for both educational and clinical settings.

6 Sep 2017, 16:00-17:00 (NA024) Poster

Safety and Usefulness of Returned Ampule Sorting Machine – toward the Realization of Virtual Cassettes –

Koichi Takahashi, Kazuko Higuchi, Kazunori Yamaguchi, Nami Mizukawa, Takato Nozaki, Naoki Shinohara, Hiroaki Tanaka, Masato Asakura, Shinji Kosaka, and Hitoshi Houchi
Kagawa University Hospital, Japan

Background
In general, injections are sent to wards in the form of ampules and vials without mixing in Japan. Unused injections returned to the pharmaceutical department were previously sorted by technical assistants, double-checked and restocked to injection depositories by pharmacists, in which ensuring safety was one of the main challenges. To improve safety of our work, we incorporated Returned Ampule Sorting Machine (hereinafter, "restocker") into existing Ampule Dispensing Machine (hereinafter, "picker"), and studied the usefulness.
Methods
The restocker automatically reads barcodes and prints of randomly placed returned injections to sort them and verify their expiring dates. Restocked injections are dispensed according to patient prescriptions. Both picker-stocked and unstocked items were subject to returned injections. Safety: Accuracy of the restocker was calculated on restocking more than 10,000 returned injections between June through August in 2014. Usefulness: Between June 13 through September 17, 2015, results of dispensing of returned injections according to patient prescriptions were investigated.
Results
Safety: A total of 10,275 injections were sorted, all of which were correctly identified. Usefulness: 19522 of all returned injections were dispensed to patients, of which 1841 (9.43%) were items not stored in the picker. No dispensing errors occurred.
Discussion
Introduction of the restocker resulted in no errors in sorting and dispensing to patients of injections, which suggests the restocker is valuable for improved safety in restocking procedure. Furthermore, realization of so-called virtual cassettes, which enable dispensing picker-unstocked injections, would lead to further improved safety of our procedure.

6 Sep 2017, 16:00-17:00 (NA082) Poster

To Improving patient safety and Effective traceability of surgical instruments during sterilization process using GS1 standards

Shingo Kasamatsu, Yoko Ishimoto, Kazue Suwa, Naomi Emori, Kazufumi Sato, Koichi Uemura, Hironobu Akino,
University of Fukui, Japan

University of Fukui Hospital launched a new integrated sterilization management system using GS1 identification keys in 2014. Our Hospital succeeded to secure traceability of the sterilization process and the use history for surgical instruments by identifying all 18,000 instruments with GIAI in laser engraved GS1 DataMatrix. Through this journey we have so far achieved reduction of assembling operation time by 2,000 hours per year in addition to the error-rate reduction. Furthermore the surgical container setting system utilizing GLN location information could reduce the operation time by 500 hours per year. This is the first practical use of GLN in a Japanese hospital. With the implementation of GS1 standards achieved cost-effective management of a workflow.

6 Sep 2017, 16:00-17:00 (NA034) Poster

Checking failures and the estimation of risk-taking behaviors: A cross-sectional survey in a university hospital-

Masako Fujii, Hironobu Akino, Kazuyo Terasaki, Yoshimi Kuwabara, Kimiko Kitahama
University of Fukui, Japan

Objectives: To determine the relationship between checking failures by nurses and their perception of risk-taking behaviors, based on a cross-sectional survey in our university hospital in Japan.

Methods: The entire population of nurses at our hospital (n=609) were enrolled in the study. The self-completed confidential survey requested the respondents' basic information, their experience of checking failures-related incidents within the prior 3 months and self-assessment of the degree of risk and the respondent's probability of engaging in risk-taking behaviors in four situations: daily-life, traffic, oral drug administration, and intravenous drug administration. The self-assessment of the degree of risk or the probability of a behavior's performance was scored from 0% (quite safe or never do so) to 100% (extremely dangerous or surely [in all occasions] do so).

Results: The nurses who had experienced a checking failure-related incident were younger, their length of career as a nurse was shorter and their self-assessment score of the probability of performing risk-taking behaviors in the situation of oral or intravenous drug administration was higher compared to those who had not. Multivariate analyses revealed that experiencing a checking failure-related incident was significantly associated with a shorter career as a nurse and a higher self-assessment score of the probability of engaging in risk-taking behaviors in the situation of oral drug administration.

Conclusions: This study showed that checking failures are associated with a higher probability of performing risk-taking behaviors.

6 Sep 2017, 16:00-17:00 (NA054) Poster

Simulation Training for Patient Safety in Neurosurgical Emergency - PNLS:Primary Neurosurgical Life Support

Megumi Takahashi, Masahiro Wakasugi, Hiroshi Okudera, Hisashi Nakashima, Mie Sakamoto, Mayumi Hashimoto, Emiko Asaka
Department of Crisis Medicine and Patient Safety, Graduate School of Medicine, University of Toyama, Japan

Current neurosurgery is dramatically advanced by technologically innovations and become complicative. Therefore, Patient Safety in neurosurgical patient care is essential to achieve successful neurosurgical outcome. We developed PNLS, Primary Neurosurgical Life Support, as simulation training of patient safety for neurosurgical care staff such as resident, nurses and co-medical staff in 2009. PNLS is designed as half day training course with simulation-based curriculums with learning and assessment objectives which are to be accomplished, and published PNLS course guide book. Basic structure of GIO and SBOs of PNLS is designed as follows:
GIO: Learn an appropriate response to acute stage of neurosurgical patients and a leadership in Neurosurgical team for Patient Safety.
SBO:1) Life support skills including BLS (Basic Life Support) and AED, 2) Airway management and monitoring, 3) Early detection and management of cerebral herniation, 4) Learn and discuss the representative neurosurgical cases.
In 2010, World Federation of Neurosurgical Societies adopted the PNLS as a tool of education course in developing countries.
In 2015, Japan Resuscitation Council (JRC) Guideline is revised according to International Consensus on cardiopulmonary resuscitation and emergency cardiovascular care Science with Treatment Recommendations by International Liaison Committee on Resuscitation. PNLS is based on the concept of neuroresuscitation listed in JRC Guidelines and revised by 2015 Guidelines.
Our experience of domestic and international PNLS and impact on patient safety in neurosurgical patient care will be presented and discussed.

6 Sep 2017, 16:00-17:00 (NA065) Poster

Relationship between professional experience as a practicing dietitian and health status or dietary awareness among graduates of a department of food science and nutrition

Minatsu Kobayashi, Sayo Uesugi, Reiko Hikosaka
Otsuma women's University, Japan

Objective: The aim of this study was to clarify the relationship between employment history and health status or dietary awareness of a department of food science and nutrition graduates.
Methods: One hundred and one women aged 55.8±3.4y who graduated from a department of food science and nutrition from 1975 to 1984 were assigned to tertile classification by employment history (< 9y, 9y to 25y, 25y ≤). In the study on health status, eight subscales and three summary scores were calculated for the health-related QOL by the SF-36 survey form. To assess the association between employment history and eight subscales and three summary scores, test for trend were analyzed with adjustment of age, stress presence, marital status, disease history and sleep duration. In the dietary awareness study, we asked about being cautions “purchasing food items "",""deciding dishes when eating out”, and ""daily dietary custom"". We conducted the Cochrane Armitage trend test on the difference between employment history and dietary awareness.
Results: The employment history was associated with physical functioning (P trend=0.007), role limitations due to physical health (P trend=0.029), and Energy/fatigue (P trend=0.006). The subjects who have been working as dieticians did not distract with price at the time of purchasing food items (P trend=0.009) and the selection of dishes when eating out (P trend=0.043), and pay attention to balanced nutrients.
Conclusion: Because the subjects of this study had expert knowledge about food, they practiced preferable eating habits. While the professional experience contributed to the physical health and dietary awareness.

6 Sep 2017, 16:00-17:00 (NA083) Poster

Comparison of Delivery Outcomes between Clinics and Comprehensive Perinatal Care Centers

kyoko KANAMORI, Kumiko IWATANI, Miwa IZUHARA
Kyoto Koka Women's University, Japan

Objective: To compare delivery outcomes between clinics and comprehensive perinatal care centers (centers) as advanced medical institutions.
Methods: A cross-sectional, retrospective, observational study was conducted, involving 1,738 females who had experienced delivery at a clinic in 2009 (clinic group) or at a center between 2012 and 2013 (center group). Questionnaires were distributed and collected to extract members with lower risk levels from both groups. Risk scores and delivery outcomes were analyzed, while regarding conditions, such as a period of gestation shorter than 37 weeks, a bleeding volume of 1,000 ml or higher, emergency cesarean section (CS), and vacuum extraction (VE), as abnormal labor. Analysis was performed using SPSS, the t-test, and chi-square test. The study was approved by the relevant ethics committee (September 2012; approval number: 12).
Results: Valid responses were obtained from all of the 1,738 females, 63.0% (n=1,095) of whom showed lower risk levels. The latter's mean age and rate of primiparas were 30.2±4.3 (n=1,095) and 44.4% (n=486), respectively. Among them, clinic and center group members accounted for 74.8 (n=819) and 25.2% (n=276), respectively, showing differences in risk scores ($p<0.000$). As for delivery outcomes, a shorter period of gestation, emergency CS, and VE were significantly more frequent in the clinic group, while excessive bleeding and poor 1-minute Apgar test results were significantly more frequent in the center group ($P<0.001$).
Conclusion: It may be necessary to establish systems to rapidly transport patients from clinics to centers.

6 Sep 2017, 16:00-17:00 (NA114) Poster

Developing a ward round checklist to improve patient safety

Ismail BOZKURT, MD, Chief of Continuous Quality Improvement Department / Medical Director
Burcu BOZKURT, Nursing Manager
Deniz KUCUKLER, Nursing Manager
Fatma KUCUKERENKOY – Manager of Continuous and Quality Improvement Department
Vehbi Koc Foundation American Hospital, Turkey

BACKGROUND
Medical ward rounds are complex activities; critical to providing high quality safe care for patients in a timely relevant manner. They provide an opportunity for the multidisiplinary team to come together to review a patient's condition and develop a coordinated plan of care.

PURPOSE
Develop and implement a ward round checklist and improve patient care quality and safety.

MATERIAL AND METHOD
To evaluate medical ward round system a working group was formed by consisting of the members of Medical and Nursing Services and Department of Continuous Quality Improvement.
The PDCA (Plan, Do, Control, Act) cycle management method was used.
The existing approach to current practise was evaluated and risks and hazards to patient safety were identified by analyzing the reports of unexpected events retrospectively.
The checklist was formed to promote awareness among health care staff with the aim of preventing the identified risks before they lead to harm. This gives users the opportunity to pause and take stock of their actions.
The checklist was also used as a tool to transfer the essential patient information to the health care staff.
New process was defined in hospital policy to ensure consistent practice.

RESULT
The hospital evaluated the effectiveness of the project and it was highlighted that the fall rate was reduced by 18% where as the medication error rate was reduced by 45%

CONCLUSION
The daily process of reviewing patient requires careful preparation, prioritization, attention to detail and continuous revaluation. Checklists can have a significant positive impact on health outcomes, including reducing patient harm.

6 Sep 2017, 16:00-17:00 (NA143) Poster

A descriptive study on medical error incidents including near misses related to insulin injections in a hospital in Japan

Kumiko Asakawa, Mihoko Kondo,Masako Fujii,Naomi Emori,Tomoko Hasegawa
University of Fukui Hospital, Japan

Purpose:
In order to create medical error prevention measures, this study tried to classify medical error incidents including near misses related to insulin injections in a hospital.
Methods:
Medical error records related to diabetes mellitus: MD treatments reported between 2012 and 2016 were reviewed, and incidents including near misses related to insulin injections were collected. The near miss is an event or situation that did not harm the patient.
Ethical consideration:
Individual information in the records were eliminated and all data were anonymized in the medical records department before analysis.
Results:
There were 293 (mean 59/year) error incidents related to DM, and 144 (mean 29/year) incidents were related to insulin injections. Highest frequency of the incidents were occurred in the endocrine metabolic department. Incidents were reported in almost all departments in the hospital. 97％ incidents were reported by nurses; half of the nurses’ had clinical experiences between a few months to 2 years. Frequently occurred incidents were “missing administration (40%),” “overdose administration (17％),” and “miss-dispensing (11%).” Insulin related incidents which produced patients injuries have been decreasing.
Discussions:
Since insulin related medical error incidents were made by inexperienced nurses, insulin related procedures may not taught enough in basic nursing education system. Intensive educations were needed for newly graduated nurses. Because insulin related incidents have been decreased, risk management measures, such as risk management committees, chief nurse committees, public relations, and safety patrols could prevent medical error incidents in the hospital."

6 Sep 2017, 16:00-17:00 (NA144) Poster

The Usefulness of "Partnership Nursing System" to prevent Alarm Fatigue in ICU

Yukie Takayama; Mayumi Tada; Shingo Haneda; Mayumi Miyamae; Shinpei Ohtsuka, Anna Watanabe; Naomi Emori;
Tetsuo Fujibayashi; Kazuhiro Kikyo
University of Fukui Hospital, Japan

Key words: ICU, Alarm fatigue, Nurse, Partnership Nursing System (PNS)

Purpose. The purpose of this study is to examine the effect for alarm fatigue prevention by clarifying the actual environment of physiological alarm (Alarm) and evaluating nurse's perceptions and actions to the alarm.
Methods. Alarm date were collected from April 2016 to December 2016. Total alarms were 349832 times. Using Alarm Reporting System, evaluate the relation with actual alarm situation by questionnaires survey on nurse's recognition and response.
Result. Total number of alarms was 359832. After PNS introduced, Number of alarms indicating anomalies of patient has decreased by 20%, vital alarms decreased by 45%, technical alarms decreased by 50%. Percentage of cases that required over 30 seconds to correspond was reduced from 19% to 4.7%. Questionnaires to ICU nurses suggest that nurse behavioral were changed, such as "Always conscious of the alarm and notify other nurses" "change or reset the parameter for each patient" "Leader nurse alerts nurses about alarms".
Conclusion. Adopting of PNS in ICU caused changes in action of nurse and usefulness for alarm fatigue prevention was confirmed.

6 Sep 2017, 16:00-17:00 (NA156) Poster

Relationship between postmenopausal symptoms and dietary intake of youth by longitudinal study

Sayo Uesugi, Minatsu Kobayashi, Reiko Hikosaka
Otsuma Women's University, Japan

Background/Objectives: The incidence of fracture was >10 % in elderly and >20 % in young Japanese women who have a body mass index < 18.5. We aimed to investigate the association between the health status or postmenopausal symptoms among middle-aged women and their dietary intake when they were younger.

Methods: The subjects were 224 Japanese women, aged 49 to 63 years, who were university graduates between 1975 and 1984. A survey was performed using a self-administered questionnaire, between 2011 and 2014, and the dietary intake of the participants was assessed using a food frequency questionnaire (FFQ). The FFQ was used to determine the usual consumption of 138 foods and beverages during the previous year with standard portions/units and nine frequency categories. A total of 206 women responded to the questionnaires, with healthy status, medical history, attention to, or habit of diet and had postmenopausal symptoms. Moreover, we documented dietary record survey for 3 days on the university register of subjects. Individual energy and nutrient intakes were then calculated using the Standardized Tables of Food Composition, 5th revised edition. All statistical test were conducted using SPSS Ver. 21.0 (IBM JAPAN, Inc., Tokyo, Japan). All p values were two-sided, and statistical significance was determined at the level of $p < 0.05$.

Results: The postmenopausal symptoms caused by decreased estrogen secretion were associated with the intake of tocopherol, poly unsaturated fatty acid, and n-6 unsaturated fatty acid when they were younger. Therefore, we need a detailed analysis, adjusted for various confidence factors.

Abstract

7 Sep 2017 Oral

7 Sep 2017, 9:30-10:00 (SL: NA161) Oral

Strategic communications for medical professionals at the time of crisis : Basics of crisis management and their applications to the cases in healthcare settings

Hajime SATO
Department of Health Policy and Technology Assessment, National Institute of Public Health, Japan.

There are increasing risks of natural and man-made crises, possibly leading to disasters. They include cyclones/ typhoons, earthquakes, incidents of industrial plants, traffic and aviation accidents, virulent flu and in-hospital infections, malpractice, and terrorism attacks. Effective management of health crises is more and more called for. Healthcare organizations and professionals should be sufficiently prepared for them.
After reviewing the concepts of risk, issue, and crisis, this presentation introduces the basic components of their management. Depending on the phases of crisis, namely before, during. and after the crisis, a set of actions are required with advanced planning and coordination: They are preparation/ mitigation, response, and recovery, besides the efforts for prevention. Well-structured incident command system, and communication functions are core part of them.
Planning and actions against crisis in healthcare settings are to be done in accordance with the basic principles on crisis management. Efforts to prevent an issue/ incident from becoming a crisis are quite imperative, along with those to contain, resolve, and recover from a crisis once it occurs. Communications duly play a key part in them. Points and caveats are proposed and discussed, when applying those principles to the health-related issues/ crises, especially where sufficient commitments of healthcare organizations are warranted, including the cases of medical incidents and malpractice issues.

7 Sep 2017, 10:00-10:30 (SL: NA023) Oral

Cardiac Troponin T could be safely used without CK and/or CKMB to rule out acute myocardial infarction in and emergency ward setting.

Stacy E.F. Melanson MD PhD, Milenko J. Tanasijevic MD MBA
Brigham and Women's Hospital, Harvard medical School, USA

We have examined the impact of removing CK and CKMB from the ordering formulary of our ED and relying solely on cardiac Troponin T in establishing the diagnosis of an acute myocardial infarction.
The chart review demonstrated no loss of sensitivity and substantial cost savings to the laboratory as a result of the intervention. Cardiac troponin alone is sufficiently sensitive for triaging patients with acute chest pain, while offering a superior cardiac specificity to that of Ck and CKMB.

7 Sep 2017, 10:30-11:00 (SL: NA060) Oral

Reducing Nursing Interruptions to Improve Patient Safety

Prof. Linda McGillis Hall
University of Toronto, Bloomberg Faculty of Nursing, Canada

Background:
Little work has aimed at understanding and acting on the complex processes and interruptions in the nursing work environment that may contribute to patient safety incidents.

Aim and Objectives:
The objectives of this study were to: a) identify the types of systems-related interruptions that are occurring in nursing work environments, b) implement a change intervention to decrease these work interruptions and c) compare differences in patient safety outcomes pre- and post this change.

Method:
A quasi experimental pre-test post-test, control group research design was used in this study involving work observation; focus groups; a change intervention; and assessments of differences in patient safety outcomes following change. The study took place in 9 adult acute care hospitals on 36 similar adult medical surgical units across 3 provinces in Canada and involved 321 nurses and data on 12,900 work interruptions.

Findings:
Following completion of the intervention, the overall volume of interruptions was reduced. In addition, a 5% reduction in errors related to 'wrong drug administered', and a 2% reduction in 'communication breakdowns' was noted. As well, an increased sensitivity towards the impact of interruptions was evidenced, as a 4% increase in 'near misses' was found.

Conclusions/Implications:
Staff are interested in participating in changes to reduce patient safety events when given the opportunity to shape the process of care. A number of key environmental factors were highlighted as impacting interruptions including technological factors and environmental noise. Several of these formed the basis for the work redesign initiatives that were implemented.

7 Sep 2017, 11:00-11:30 (SL: NA091) Oral

Lessons Learned from a Medication Error: How Safety Culture Mitigates Harm to Both Patients and Clinicians

Director & Assoc Prof, May C M Pian-Smith, MD, MS
Harvard Medical School, USA

Anesthesiologists are responsible for ensuring comfort during surgical procedures and protecting patients' safety. Despite our very best efforts, sometimes things go wrong.
In the immediate response to an adverse event, attention is focused on managing, reversing or minimizing the harmful effects to the patient. In the aftermath, a root-cause analysis is conducted to identify contributing factors to the error. Often this analysis identifies multiple factors, including those that are related to the system in which care is given, and some that are related to the individual who is providing care. By deliberately linking the root cause analysis to specific process-improvement and educational interventions, we are able to help assure the error is less likely to happen to another patient. Effective analyses and sustained improvements can only happen when there is commitment and openness to learning and improving. This necessary "safety culture" can be elusive in work places where there is fear about reputation, retribution, litigation and appearing anything less than perfect.
This presentation will include a description of an actual medication error that resulted in harm to a mother and her unborn baby. The story will include aspects of the root cause analysis that led to institutional changes in medication delivery systems. It will also include a description of the processes of admission of guilt, and disclosure and apology to the patient and her family. It will include a description of the "second victim" and "third victim" phenomena, where the involved clinician can be traumatized by the event and how this can negatively impact care given to subsequent patients.
The case discussion will highlight the importance of the work place "safety culture" for recovery from events and resilience of individuals and systems. Specifically, there will be a discussion of techniques that can be employed to improve safety culture, including being transparent about adverse events, improving communication and flattening hierarchies, and providing peer support.

7 Sep 2017, 11:30-11:50 (NA118) Oral

Successful Applications of High Reliability Organization Methods to Improve Patient Safety and Actions Required to Accelerate Progress

Howard W Bergendahl JD, MS, CPPS
The Bergendahl Institute, LLC, USA

Purpose/Objective:
Healthcare organizations worldwide are embracing the practices of High Reliability Organizations to improve Patient Safety. These efforts are being met with varying degrees of success. This paper summarizes which new practices are working well and where new thought processes are needed.

Materials and Methods:
Since the Institute of Medicine report emphasized the need for cross-industry learning in 1999 many new practices from High Reliability Organizations have been adopted by healthcare. Successful new practices and processes are resulting in improvements in outcomes, patient safety and safety culture. There are however some proven practices that have not been accepted or have failed to achieve widespread acceptance. Several of these initiatives have been reviewed to in order to identify the barriers to incorporation that remain.

Results:
As expected, the cultural differences between industries have had a large impact on the degrees of success, and the expected regulatory and legal challenges have hindered some progress. However, more fundamental factors have been identified and also play a role. These factors include contributors such as basic human behaviors and communications.

Conclusions:
Some early successes in the transfer of good practices from other industries have been realized. The impact of human behaviors and communications appear to require more attention. Although a new generation of Healthcare workers will facilitate much of the future change, new models to define and communicate future direction will be required. Many of these models already exist and should be incorporated into healthcare organizations today.

7 Sep 2017, 11:50-12:05 (NA116) **CLOPIDOGREL PHARMACOGENETICS: A VALID METHOD TO ASSURE FFECTIVENESS AND SAFETY OF THE ANTIPLATELET THERAPY**

V. Conti, V. Manzo, C. Sellitto, T. Iannaccone, M. Costantino, G. Corbi, P. Malangone, G. Nicolella, G. Accarino, A. Filippelli
University of Salerno, Italy

Clopidogrel is an antiplatelet agent commonly administered to prevent thromboembolic events in patients with peripheral and coronary artery disease after stent placement. It is a pro-drug converted into active metabolite by hepatic cytochromes, including CYP2C19.
Reduction of antiplatelet activity and increased adverse events frequently occur in patients bearing CYP2C19-*2 and -*3 polymorphisms. Moreover, the effectiveness of clopidogrel is affected by drug-drug interaction with proton pump inhibitors (mainly omeprazole) that strongly inhibit CYP2C19.
We report a case of a man with carotid artery stenosis, on treatment with clopidogrel, aspirin and omeprazole, admitted to University Hospital of Salerno-Italy for a percutaneous transluminal angioplasty (PTA).
Patient's antiplatelet aggregation was measured by platelet function testing and clopidogrel pharmacogenetics was made by allelic discrimination with Real-Time PCR.
Before PTA, the patient had an aggregation rate corresponding to a value occurring in the absence of treatment and pharmacogenetic testing revealed the presence of CYP2C19*2 allele.
Taking into account the insufficient platelet aggregation inhibition, the presence of CYP2C19*2 allele and the inappropriate use of omeprazole, the therapy was changed by replacing omeprazole with ranitidine and by administering a supplemental dose of clopidogrel.
Then, the patient repeated platelet functional testing, showing a value well suited with a therapeutic effect of clopidogrel.

Patients who do not adequately respond to clopidogrel have a 5-10 fold increased risk for stent thrombosis, whereas the regular responders' risk is very low. This case report emphasizes the importance of monitoring the antiplatelet therapy and confirms the role of the pharmacogenetics in assuring pharmacological appropriateness.

7 Sep 2017, 13:00-13:20 (NA110) Oral

Evidence under threat: risk communication in an era of alternative facts

Thomas Rowsell
Uppsala Monitoring Centre, Sweden

Background: Experts and scientific evidence are under attack in public policy and popular discourse. While individual health practitioners remain respected by many, there is a growing climate of skepticism and denial in relation to public and personal health issues; confusion and uncertainty about controversial science-based issues; and a strong drift towards irrationality and belief-based choices. These pose a threat to science and scientific thinking and to risk communication practice and the safety of patients.
Objectives: This presentation will review some of the trends that are threatening public respect for evidence and safety communications and point to some options for future practice.
Methods: The work behind this presentation is part of a larger project examining how medicines information can recover from its failure to deliver full benefits in an increasingly complex political, social and philosophical context.
Discussion: Evidence must be communicated in ways that not only make it useful, but that also acknowledge and manage the extraneous obstacles that stand in the way of its visibility and acceptability. Recovery requires specific focused action within each of the branches of science, and a large, radical coalition, like that symbolically manifested in the March for Science.
Conclusion: The rise of populism will probably continue, and respect for experts, evidence and rationality will decline in the years ahead unless strong, imaginative measures are taken soon. The presentation will end with suggestions about some novel approaches to mitigate the problems that could benefit the practice of risk communication and the safety of patients.

7 Sep 2017, 13:20-13:40 (NA013) Oral

Accreditation - An Australian Perspective on the Impact of New Mandatory Standards - Opportunities and Challenges for Leaders and Managers

Sandy Thomson
Quality Systems and Assurance Services Pty Ltd T/A GovernancePlus, Australia

The 10 Australian healthcare National Accreditation Standards for Safety and Quality became mandatory in January 2013. These Standards comprise 256 actions of which 208 must be met to achieve or maintain accreditation.
This presentation involves data from 59 Australian health care organisations who have participated in our pre survey preparation program from 2012-2017 which occurs up to 6 months out from actual survey. The pre survey methodology involves interviews with Board members, Executives, Consumer Representatives and a patient journey risk assessment “Are You Ready for Me” at the ward/departmental level. The process is both collaborative and educational and enables open conversations about the status and risks with patient safety systems.
Of the 11421 mandatory actions assessed to date 28% were rated as Not Met thus presenting a risk of non accreditation. Importantly Not Met ratings identified patient safety issues that in many cases were not known about or identified by internal controls. Key areas of Not Met are in Governance, Consumer Participation, Infection Control, Medication Safety and Handover and are generally due to more stringent evidence requirements, internal reforms associated with changes in leaders and governance models and external reforms associated with government policies. Actions generally meeting requirements are patient identification, blood management, clinical deterioration, falls and pressure injury prevention. Following collaborative support 99% of participating organisations achieved a successful accreditation outcome. Organisations continue to use this service as part of their quality program.
Findings are that use of pre survey assessments means organisations are better prepared and the element of a surprise adverse finding at survey is significantly reduced.

7 Sep 2017, 13:40-14:00 (NA119) Oral

Antipsychotic associated metabolic monitoring: How well are we doing it?

Racha Dabliz, Mental Health Pharmacist, Concord Centre for Mental Health,
Seniha Karacete, Senior Mental Health Pharmacist, Concord Centre for Mental Health,
Angela Meaney, Clinical Nurse Consultant Physical Health & ccCHIP Clinics, Mental Health Service,
Bonnie Tse, Psychiatry Trainee, Concord Centre for Mental Health,
Concord Hospital- Concord Centre for Mental Health, Australia

Background: Antipsychotic medicines remain the key treatment of schizophrenia, despite significant metabolic side-effects associated with early onset of cardiovascular and metabolic disease. There is a notable increased incidence of preventable premature mortality in persons with major mental illness compared with the population overall1. Metabolic monitoring is expected to identify those patients who require early intervention to prevent future complications and premature mortality. This study aims to identify the percentage of patients taking antipsychotic medications who receive appropriate monitoring for the development of metabolic side effects in an Australian inpatient mental health setting, with a view to improving practice.
Methods: Sampling was retrospective and the files of all patients who met the inclusion criteria were reviewed until the sample size was obtained. Parameters audited were completion of metabolic monitoring including waist circumference, weight/BMI, blood pressure, fasting lipids, and fasting BGL or HbA1c.
Emerging findings: In depth findings from the baseline audit indicated suboptimal metabolic monitoring across individual parameters, particularly waist circumference (22%) and fasting lipids (66%), and poor overall compliance with documentation standards (n=99). A series of targeted interventions have been developed in response to the findings and a repeat audit is underway.
Conclusions: Although the metabolic derangement associated with antipsychotic use are well recognised, metabolic monitoring remains poor and inconsistent. This study identifies specific gaps in practice and trials targeted actions to address these gaps.

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7 Sep 2017, 14:00-14:20 (NA025) Oral

Values, meaning and perspectives for healthcare professionals : impact on patient safety

Sophie Garcelon
WING SANTE, France

My experience as a lawyer, specialised in Medical Risk Management, having worked for many years for healthcare professionals and institutions insurers, will guide my presentation.

The presentation will start with an overview of Medical Malpractice claims through French insurers' publications, as well as incidents declarations. We will show that, on that perspective, the number of claims or incidents is still very high, despite the launching of risk management programs through, among other things, Accreditation.

We will also talk about the issue of Quality of Life at work, and its impact on the Quality of care, through various studies published in France. The question of « avoiding useless claims » will be adressed.

We will then present exemples of projects launched in several hospitals that have had an impact both on the quality of life of professionals, reduction of conflicts and on patient safety. At least, to exemples will be developed :
- The decision of a Director to work with his Board and management staff on « Values and meaning of work », in order to enhance team spirit and transform « values » into « actions »

- The decision of a Service Director (Surgeon), to use the « Patient Path » method in order to increase team cohesion, professionals' and patients' satisfaction.

Some exemples of major gaps between admnistrative and medical staff will be highlighted and will open the discussion.

7 Sep 2017, 14:20-14:40 (NA073) Oral

Patient Safety and Risk Management: a lesson from the Aerospace industry - IT integration with Electronic Medical Record (EMR)

DOMENICO MANTOAN, BARBARA CAMERIN, ANDREA BOER, MARINA BRATTINA, LORENZO GUBIAN, FABIO CASSAN, GIACOMO VIGATO
VENETO REGION - HEALTHCARE ORGANIZATION, Italy

The public healthcare organisation of Veneto Region, Italy, is adopting new strategies and tools for risk management and quality. Similarly to Aerospace industry, combining information technology and training, our target is the transition from reactive to proactive clinical safety .This will be done by collecting and processing data, to detect latent problems and develop targeted actions for improvement. Related data flows are nowadays collected from claims, sentinel events, voluntary reporting.
The novelty that we propose is the direct link with the electronic patient data (EMR, EHR).
Together with a database of guidelines and best practices that will show all informations immediately available to professionals. A computerized dashboard will show several categories of data and taxonomies, each interconnected with a risk management section, indexed and processed into charts and graphs to visualize regional and local risks trends of adverse events. So, like the flight data monitoring (FDM) and the engine monitoring system (EMS) in airplanes, the software will automatically warn for risk parameters. A big data system will then support the operational units at each level, from the front line to the top management and will monitor not only the risks related to patient healthcare but also the communication and organizational issues, showing a “big picture” for decision makers. This will be a benefit for safety, quality, reduction of litigation and insurance costs. The project will take into account all patient privacy aspects. Health professionals and managers will be trained on this new metodology also with simulation and mobile applications.

7 Sep 2017, 14:40-15:00 (NA007) Oral

The Safe Practice of Acupuncture

Dr. Steven K.H. Aung
University of Alberta, Canada

In Traditional Chinese Medicine (TCM), acupuncture is one of the mainstream complementary medicines. It is very important to practice any kind of medicine with consideration for the safety of all involved. The use of disposable and sterilized needles is an obvious requirement, and carefulness with the placement or movement of needles around the sensory and vital organs is critical to performing safe and effective acupuncture. Simultaneously, some patients inherently demand more caution and cannot be treated with certain acupoints, such as pregnant women, those with pacemakers, those with blood diseases taking blood-influencing drugs, the mentally ill, and the otherwise severely diseased. Acupuncture and related techniques have the potential to interfere with other medical devices. In the case of epilepsy patients, neurological assessment must be performed prior to receiving treatment. It is also extremely important to consider cancer or the lack thereof, and ignorance of this can lead to the subsequent use of techniques that are unintentionally harmful to the patient. The best way to practice acupuncture is to always do so with compassion, care, and consideration for their current state and safety.

7 Sep 2017, 15:00-15:20 (NA011) Oral

Considering the "Second Victim": ICARE for the Caregiver, Peer to Peer Support

Bonnie Portnoy, Senior Director, Risk Management & Patient Safety, Mount Sinai Health System (MSHS); Erica Rubinstein MS, Senior Director, Patient Relations & Service Recovery, MSHS; The Mount Sinai Hospital, Vicki Lopachin MD, CMO, USA

The Mount Sinai Hospital (MSH) launched its ICARE Team to address the emotional needs and well-being of staff involved in an unanticipated medical event, medical error and/or patient related injury. Addressing the needs of the "Second Victim" is critical to the future well-being of the caregiver, as well as other staff. Through a confidential peer to peer support service, ICARE provides critical incident stress management interventions for individuals and teams, as well as referrals when needed. All team members participate in an intensive training program.
Our mission is to promote a culture of sensitivity by providing support and respect to caregivers involved in a stressful or adverse event. Our goals are to increase institutional awareness of the "Second Victim' phenomena provide consistent and targeted system wide guidance and support for the caregiver and provide additional resources for the team, to effectively support staff involved in these events. Lack of support can be associated with staff turnover, decreased productivity and increased workers' compensation claims. Adverse events are ubiquitous and creating a system to address caregiver needs in the aftermath of an adverse event is critical. Our thoughtful, thorough approach to supporting "Second Victims" can be replicated and can benefit other healthcare institutions focused on the well-being of their staff during difficult times

7 Sep 2017, 15:20-15:35 (NA048) Oral

Assess The Culture Of Patient Safety Through Humpty Dumpty Fall Scale (HDFS) Evaluation

Ola Magdy Torky ,Shaimaa El Meniawy
Children's Cancer Hospital Egypt 57357, Egypt

Introduction:-
Child fall is a very serious event and is being recognized as an indicator of patient safety for health care organizations.
As children cancer hospital in Egypt(CCHE) 57357 vision, mission and strategic goals for patient centered pain alleviation, protect patient from fall is one of international patient safety goals (IPSGs).
Nurse plays an important role in culture of patient safety through her awareness about fall prevention program.
Literature review:
1- The current lack of supportive research to validate HDFS.
Further studies to validate the reliability and validity of the fall risk screening tool used at Children's Hospital will improve the efficiency and effectiveness of care and promote a safe environment for pediatric patients.
Significance of the Study:-
1- Protect patient from fall is one of international patient safety goals IPSGs (Goal NO 6)
, Humpty Dumpty fall scale (HDFS), A tool used to assess fall risk through:
Humpty Dumpty Tool sensitivity & specificity.
The effect of individual approach on fall scoring.
The effect of process (scale related factors) on fall scoring.
Nursing questionnaire.

2- HDFS recognizes the predictive ability to identify hospitalized children at risk for fall.
Aim of the study:
1-Achieve substantial increases in reliability of HDFS over present levels of patient safety regarding fall.
2-Promote a culture of patient safety through individual approach.

Research Questions:-
1- Dose HDFS address a fall prediction?
2-Evaluate An Existing Fall Prevention Program:
A-In the pediatric acute care setting, what is the sensitivity & specificity of the Humpty Dumpty Fall Assessment Scale (HDFS) in predicting hospitalized children's fall risk?
B-How can Humpty Dumpty Falls Scale (HDFS) Adapt Culture Of Patient Safety?
C- How dose nurse evaluate HDFS?

Research Methodology:-
A:-Research Design
Descriptive and Retrospective hypothesis test case design will be utilized for this study.
Using lean concept six sigma methodology tools in improvement process through problem define, measure, analysis, improve & control.
B:-Subjects:
Pediatric inpatient undergoes *invasive procedure at procedure room under general anesthesia & stay for at least 12 hrs before discharge (2 nursing shifts)
*invasive procedure (CSF, BM Biopsy & BM Aspiration)
Collected Data: *1st Ongoing Assessment (at the beginning of morning shift)
* Post Procedure Assessment (at recovery room)
* 2nd Ongoing Assessment (at the beginning of night shift)
*(Electronic assessment form contains fall risk assessment)

Sample size:
Inclusion Criteria:
Pediatric inpatient (Medical)

1- Admitted patient stays for 24 hours (*10AM -**9AM) & undergo invasive procedure with anesthesia
* Start of morning shift

**Start of night shift
Long term data collection : 1 month

Exclusion Criteria:
Outpatient Areas, OR & Inpatient Areas (Critical –Surgical: ICU, Stepdown , Surgical ICU,(Surgical wards :3D,3E) & BMT)

Practice Implications:
1-The HDFS tool, a fall prevention pediatric program fulfills the Joint Commission Patient Safety Goals(Goal No 6), but further research is needed to evaluate the tool sensitivity-specificity.
2- Avoid shortcuts
3-Avoid human subjectivity & errors

Abbreviations:
CCHE: children cancer hospital in Egypt 57357
BM: bone marrow.
CSF: cerebral spinal fluid.
HDFS: humpty dumpty fall scale.
HROs: high reliability organizations.
ICU: intensive care unit.
BMT: Bone marrow transplantation.

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7 Sep 2017, 15:35-15:50 (NA053) Oral

Trial of Exchanging Mini-Medical-Records System Shared between Patient and Doctor

Kazuhiro Okamura
Okamura Isshindow General Hospital, Japan

Nowadays digitalization of medical records provides great assistance in readability and accessibility. However, although patients have legal right to disclose their own medical records, they have difficulties in getting it without delay.
Since 2001, patients and doctors in our hospital keep detailed notes on the “Mini-Medical-Records (MMR)” system which provides interactive communication between patients and doctors contributing to not only patient’s better understanding of their disease status but also reduce medical errors found by patients by themselves such as wrong prescriptions.
MMR is printed from electronic medical record and pasted on A6 size notebook and handed to the patient immediately after every medical visit.
MMR contains list of current disease status, medical descriptions of every visit, prescriptions, laboratory data including radiologic and physiology reports, operation records, discharge summary, and message from attending doctor.
The unique feature of MMR is to set the permission to write the message from patients. For example in a case of type 2 diabetes, if doctor pointed out the 3 kg weight gain and increased levels of HbA1c in MMR, the patient may write on next visit as “I exercised more and I made effort not to take sweets and I lost 3 kg”. Patient can write down home blood pressure, home blood glucose and etc. Reviewing the interactive messages in MMR with each other helps their deep understanding of patient’s condition.
We off course always do best medical practice and the patients could share the mind in this MMR system because patients know everything which is done on the day of clinical visit. It may sound paradoxical, but one of the best way to reduce the incidence of medical lawsuits that might depend on the patients’ understanding of their disease status and efforts of doctors. Thus disclosing patients' information to them by MMR with minimum cost will produce good patient-doctor relationship. The MMR system is a bridge between the patient and doctors. It will decrease the risk of medical lawsuits.

7 Sep 2017, 15:50-16:05 (NA115) Oral

GENETIC EVENTS IN CHRONIC LYMPHOCYTIC LEUKEMIA

AURELIAN UDRISTIOIU
Faculty of Medicine, Titu Maiorescu University, Bucharest, Romania

Aim of this study is to present the latest researches in the field of molecular medicine, in terms of Chronic Lymphocytic Leukemia (CLL), emerged from the P53 gene deletion in human lymphoma genome.

Method

In recent years proved that the best technique in the investigation of malignant lymphocytes is the Fluorescence in situ hybridization (FISH). This method is used as an alternative to chromosomal banding, a conventional application in molecular medicine.

Previous results:

In the literature it was registered, in previous years, on an international study, conducted on 109 cases of CLL, 79 cases (72.5%) who had more genetic abnormalities: the remaining 30 cases (27.5%) had normal results, using FISH technology. The majority of patients, 67% (53.79) had a single anomaly and the remaining 33% had two or three genetic abnormalities. The chromosomes 14q32 /17p translocations in LLC genome, which appeared similar to some common, had demonstrated abnormalities involving IGH gene, located on chromosome14q32.

Discussion

Recent, endogenous somatic gene therapy research is a basic of trial clinical and therapeutic trial. The DNA is used to treat a disease arising as a result of mutations in chromosomal regions. In the past few years, this method has been included in the treatment of CLL, acute lymphocytic leukemia, [ALL], or multiple myeloma [MM].

Conclusion

The frequencies of P53 gene mutations and deletion in CLL can be categorized as individual biomarkers in proteomic and genomic profile for this type of leukemia that can be implemented in targeted patient treatment of personalized medicine.

Keywords: P-53 Gene, Lymphocytic Leukemia, Apoptosis, Fluorescence in Situ Hybridization

Abstract

7 Sep 2017 Poster

7 Sep 2017,16:05-17:00 (NA063) Poster

International trades and food risk reports in mass media: the case of BSE

Hajime SATO
National Institute of Public Health, Japan

Mass media can affect how people understand and react to particular health risks. Reporting of health risks during the international trade disputes, resulting from the difference in safety regulations, therefore can play a pivotal role in resolving them. This study compared the newspaper reports on BSE-related events in major national dailies between Japan and the US around the period when BSE-infected cattle were discovered in the US and the import of US beef products was banned (between 2002 and 2006). During the study period, the number of BSE-related newspaper articles increased in both the US and Japan, but the visibility of the issue was more prominent and persistent in Japan than in the US. Geographically, most of the articles had a domestic focus, but they also reported the news of each trade partner. After the discovery of BSE cattle in the US, articles of commerce and trade issues were dominant in Japan, while the incidence of BSE, agriculture, and trade dominated in the US. Overall, the US-based newspapers carried more advocacy articles than the Japanese ones. In Japan, calls for stronger domestic policy decreased, but those for stronger foreign policy increased slightly. Meanwhile, in the US, calls for a stronger domestic policy increased slightly whereas those for weaker foreign policy dropped?both only temporarily. The major rationale for policy advocacy was the economy and health in both Japan and the US. However, the balance of competing policy objectives and the rational acceptance of BSE risks were argued more in the US papers than in the Japanese ones. In conclusion, during the BSE-related dispute on health and trade, the visibility and faces of the issues in newspapers differed between Japan and the US. Acceptance of BSE-related risks was argued differently, and those differences reflected and affected the public's perception of BSE issues, the related safety policies by the governments, and the configuration of social interests in each country. The differences evident in the media could serve as a vehicle for reappraising the existing policies as well as the possible international harmonization of risk management policies.

7 Sep 2017,16:05-17:00 (NA004) Poster

Removing biopsy proximity errors through endoscopic biopsy process method change

Hyojin Shin, Mi-Hyun Yun, Jihee Jung, Sooyeon Huh
Seoul National University Hospital Healthcare System Gangnam Center, South Korea

Objective
Gangnam Center's endoscopy department performs pathology examination as providing taken specimens through gastroscopy, colonoscopy, and polypectomy. Thus, it is not only significant to take specimen in an accurate and effective way but also all other processes including delivery and receiving.
There are 4 near misses found by other departments in 2015 at Gangnam Center. A specimen error inhibits an accurate diagnosis, and it is a threat to patient's safety. Therefore, the aim of this quality assurance is to prevent near misses about a specimen through systematic management of specimens and skills developments of staffs at Gangnam Center's endoscopy department.

Methods
A survey targeting all nurses on experience of specimens of near misses and a pre-research targeting nurses who are in charge of arranging specimen have been conducted for 5 days. Through analysis of near miss problems found by other departments in 2015, absent problems that staff's negligence and entire process of specimen treatment have been discovered. Endoscopic biopsy process is reestablished based on the above factors.
Firstly, interfacing processes have been taken and changed before a specimen goes to the headquarters of the hospital from the process of taking specimen in examination rooms before specimen
Secondly, the way to use forceps is unified for preventing errors that could occur during the process of taking specimens, and all the nurses including new nurses have been instructed on how to use forceps.
Thirdly, in order to confirm overall specimen arrangement on the day of examination, the work has to be coordinated.
Fourthly, in order to prevent examinee labeling errors, examinee identification process was changed and the nurses have been educated about the changed process. (Verbal confirmation and double checking name label on the examinee ID bracelet)
Fifthly, a personal feedback is given through near miss monitoring by a nurse for arrangement of specimens. And after identifying patterns, the nurses are reeducated.
Finally, one of two specimen label printers has been changed.

Result
1) A near miss in endoscopy department filtered in through a nurse of arranging clinical specimen for proactive analysis was compared with 9 cases compared to the number of biopsies(226) and 5 cases compared to the number of final biopsy(252) and the near miss rate decreased from 3.98 % to 1.98%.
2) A near miss from other departments in 2015 was reduced from 0.03% to 0%, compared with 4 cases compared to the number of biopsies(11,563) and 0 case compared to the number of final biopsy(5,996) in 2016.

Conclusion
Through this Quality Assurance, It has served as an opportunity to recognize once again which procedures to follow for safe secure clinical specimen and accurate test results.
In order to prevent clinical specimen errors, It is important to reduce the rate of near miss and to maintain improvement activities continuously. We plan to immediately educate and arrange for ongoing training every 6 months for new nurses and nurses who are less than a year, We will keep monitoring through a nurse of clinical specimen arrangement and manage feedback to prevent clinical specimen errors.

7 Sep 2017,16:05-17:00 (NA154) Poster

Are there more incidents in the emergency department during the months of overload? Review through the back to the emergency service (ES).

Julián Alcaraz Martínez, Mamen Escarbajal Frutos, Pavlo Povzon, Sara Ramos López, Isabel Reina Nicolas, Diana Peñalver Espinosa, Beatriz E Costa Martinez, M Mar Cutillas Perez, Esther García Alfocea, M Jose Carrillo Burgos
Hospital Universitario JM Morales Meseguer, Spain

Objective:
To analyze the discharge reports of the patients who return to consult in the ER within 1 week after an initial care, in search of possible incidents in the first attention. Compare the data between two months with different care load.

Material and method:
We reviewed the medical history of all patients who attended our emergency department in February 2017, and who returned at least one visit in the next 7 days. Of these, 370 cases were analyzed to explore the existence of some failure in the first attention and the presence of security incidents. The data source has been the high computerized report. They have been analyzed by doctors of the emergency service.

Results:
Of the 4355 patients seen, 368 were identified as case. Of these, 305 (83.7%) came for some cause related to the first visit. Safety incidents were found in 32 cases, 8.7% of the re-tests (confidence interval 5.8-11.6%). Regarding the repercussion it has had on the patient, in 26.6% there was physical damage that required additional treatment and in 53.3% it has needed additional tests to check consequences. 48.1% of this incidents have been considered avoidable.
In 2013, there were 24 incidents of 366 re-examinations (6.56% with ic = 4.1% -9%). There were no significant differences with to this year (p = 0.12).
Conclusions:
8.7% of incidents have been evidenced in patients who recover within a week in the emergency room, without a significant increase compared to months of lower healthcare burden.

7 Sep 2017,16:05-17:00 (NA042) Poster

Development of Pilot Anesthesia Quality Index System in the Standard Surgery Cases

Yusuke Kasuya, Shiori Sakuma, Makoto Ozaki
Department of Anesthesiology, Tokyo Women's Medical University, Japan

Introduction:
To improve the quality control of anesthesia, an objective anesthesia management evaluation system would be required. In this pilot research, we proposed to develop an anesthesia quality index system (AQI). We hypothesized even in the low risk surgical cases, with the precise analysis, subterranean or overlooked problem might be uncovered.

Methods:
ASA PS-1 or 2 renal transplantation donor surgery cases were researched. Surgical procedure was standardized. In the induction phase, the maximum blood pressure descending rate (Max dBP/ dt (mmHg/min)), the minimum blood pressure, the hemodynamic change upon tracheal intubation were included to develop AQI. For each parameters, 95 and 98 percentile range were calculated and clinical relevance was scrutinized using multi parameters combined regression method to develop the AQI.

Results:
Ninety six cases were analyzed. Minimum systolic blood pressure was 74±14 mmHg and maximum blood pressure descending rate was 16.5±7.3 mmHg/min. Bispectral index was more than 60 or missed monitoring in the 18.8% of cases. In 5.7 % of cases at the time of tracheal intubation end tidal CO_2 value was continuously missed. In 45 % of cases baseline Bispectral index was missing. Pharmacotherapy regimens were widely variated; propofol dose for tracheal intubation was 2.2±0.5 mg/kg, and in 7.2 % cases, dose was above 3.0 mg/kg.

Discussion: Index system could reveal some unrecognized hazardous procedures in the anesthetic management. Monitoring failure was more frequently happened. Farther assessment in the relationship between anesthesia medication dose and hemodynamic parameter outlier and outcomes would be required.

7 Sep 2017,16:05-17:00 (NA029) Poster

Assessment of school zoonotic diseases awareness program among primary school students in SK Seri Selangor USJ4, Subang Jaya, Selangor, Malaysia

Shafie, H., Ahmad, N.I., and Ajat, M.
Faculty of Veterinary Medicine, Universiti Putra Malaysia

Humans are prone to be infected with zoonotic diseases from wildlife, domestic animals and the environment. It is important for public especially school students to be aware of zoonotic diseases in order to prevent zoonotic disease transmission when handling animals. This study was conducted to determine the awareness on zoonotic diseases among primary school students of Sekolah Kebangsaan Seri Selangor USJ4, Subang Jaya, Selangor, Malaysia. The awareness program conducted consists of eight modules and each module comprises of a number of activities related to zoonotic diseases education for school students. The program was divided into two phases; first phase was conducted at the school followed by the second phase in Universiti Putra Malaysia. A set of questionnaires was designed to assess the awareness and knowledge of students on zoonotic diseases. Questionnaires were distributed among the students to be answered before the students took part in the program and after the program. A total of 40 respondents were assessed. Mann Whitney U-Test was used to analyze the data by each question. Significant difference ($P<0.05$) in awareness on zoonotic diseases by each question was observed among the students before and after the awareness program. 89.1% from a total number of 35 questions had significant differences ($P<0.05$) in awareness on zoonotic diseases between before and after the program was conducted. From this study we can conclude that this program was effective and the students acquired basic knowledge on zoonoses and ways to prevent transmission after participating in the school zoonotic diseases awareness program.

7 Sep 2017,16:05-17:00 (NA077) Poster

Comparisons of Emotional Intelligence, Mental Health and Ego-resilience between Mothers of Children/Adolescents with and without Disabilities

Masumi Omori,Shin-ichi Yoshioka
The University of Shimane Izumo Campus, Japan

This study compared emotional intelligence, mental health, and ego-resilience between the mothers of children or adolescents with (study group) and without (control group) mental, developmental, or behavioral disorders. A self-administered, anonymous questionnaire survey was conducted with 79 study group and 33 control group members. Emotional intelligence, mental health, and ego-resilience were measured using the 21-item Emotional Intelligence Quotient Scale (EQS), 12-item General Health Questionnaire (GHQ), and 14-item Ego Resiliency Scale (ERS), respectively. There were no significant differences in EQS or ERS scores between the study and control groups. In contrast, GHQ scores were markedly lower in the control group, indicating that their mental health status was more favorable than the study group. In the study group, a significant negative correlation between GHQ and ERS scores was observed. Such a correlation was also observed between GHQ and EQS scores related to <situation management skills>. These results suggest that the effective use of <situation management skills> as a domain of emotional intelligence, as well as ego-resilience, positively influences mental health.

7 Sep 2017,16:05-17:00 (NA079) _ Poster

The structure of professional confidence of public health nurses

Tomoko Ogawa, Hisae Nakatani, Akiko Kanefuji, Kiyoka Yamashita
The University of Shimane, Japan

Purpose
Nurses need to act with a belief in his/her ability as a specialist to continue working without leaving the job. The purpose of this study was to investigate the structure of professional confidence of public health nurses, and to examine factors related to the professional confidence.
Methods
An anonymous, self-administered, voluntary, paper-based questionnaire was distributed to public health nurses, working full-time within an administrative agency in Japan. Questions were asked regarding gender, age, the number of years of experience, institutional affiliation, professional confidence (34 items). Item pools of professional confidence were made by researchers through systematic review of Japanese and English studies. The structure of professional confidence was cleared using exploratory factor analysis.
Results
In total, we received 600 responses (39.7%) by mail. The effective number of answers was 545 (36.1%). Respondents were 534 females (98.0%), with a mean age of 42.5 ± 10.34 years. The mean length of employment was 17.5 ± 10.67. The structure of professional confidence consisted of 4 factors (17 items). Specifically, <systematic public health activity>, <practice based on evidence>, <relationship between colleagues>, and < continuing individual support>.
Conclusion
Results of the current study indicate that the professional confidence of public health nurses was enhanced by relationships between colleagues.

7 Sep 2017,16:05-17:00 (NA148) Poster

The review of influence on the number of police reporting system by new medical accident investigation system staring from October 2015 in Japan

Ryoko HATANAKA
The University of Tokyo, Japan

This study is considered whether the medical accident investigation system influences the number of police reporting system of patient death by medical accident.
The medical accident investigation system has started from October 2015 in Japan. In the first year, October 2015-September 2016, 388 cases were reported.
In 1999, Doctors were prosecuted for the default of police reporting duty under 21 article Medical Practitioner Act. The number of police reporting increased until 2007. 246 cases were reported to police under this duty. Medical practitioner complained the police reporting system which is possible to become the trigger of prosecution.
In the background of strong role of criminal procedure on medical accidents, other system for asking liability to medical practitioners or investigating the cause of accidents had not worked well. Patients had no way to rely on criminal procedure to know the cause of accidents. In this situation, new medical accidents investigation system was hoped to play the role for medical safety instead of criminal procedure.
I reviewed the transition of the number of police reporting and the number of pursuing criminal charges in medical accidents during past 20 years. In 2015, 65 cases were reported to police and 43 cases were pursued to criminal charge. In 2016, 68 cases were reported to police and 43 cases were pursued.
Recent decreasing trend of criminal procedure could be considered the start of medical accidents investigation system influenced the number of criminal procedure by sharing the role of cause investigation and pursuing liability.

7 Sep 2017,16:05-17:00 (NA080) Poster

Ergonomic environment of elderly people and encouraging sensory stimulation

Jadranka Stričević, David Haložan, Dušan Čelan, Milan Brumen, Majda Painkihar, Zmago Turk
University of Maribor, Faculty of health science, Slovenia

Caring for the elderly and the provision of quality health and social care provides holistic treatment of the elderly. Ergonomic environment of the elderly covers the needs of the elderly for the reception and processing of external information and carrying out the reaction to the environment. It is very important for the maintenance of cognitive and motor function and for keeping the sense of quality of life, the elderly must be closely linked to the environment. For the elderly, the sensory information is a key stimulus that encourages the perception and reaction to the environment. Information that the elderly receives from the environment must be adjusted to the elderly according to the degree of his/her sensory perception and cognitive perception. Motor response of the elderly must be appropriately facilitated with the assistance of other persons and the MTP at reduced motor skills. The decline of all abilities (sensory, cognitive and motor) must be actively detected and all the ergonomic support measures must be implemented for the elderly. Already a milder sense of reducing the opportunities to engage in the environment outs a mental strain on him and puts him in a passive state and isolates him and gives him a sense of reduced quality of life. Versatile ergonomic adjustment of the environment may significantly reduce such negative feelings.

Keywords— elderly, sensory stimulation, ergonomics, quality of life.

7 Sep 2017, 15:40-16-40 (NA072) Poster

Monitoring Critical Values in Primary Care as a Patient Safety Strategy

Moreno-Campoy EE. Dirección General de Investigación y Gestión del Conocimiento. Consejería de Salud.
Mérida-DelaTorre FJ. Laboratorio Clínico. Área de Gestión Sanitaria Serranía. Servicio Andaluz de Salud
Direccion General de Investigacion y Gestion del Conocimiento. Consejeria de Salud de Andalucia, Spain

Patient Safety seeks to minimize frequency and severity of adverse events. In this field, the Medical Laboratory's actions in response to critical values (CV) stand out. Currently, there is no consensus on what values should lead to notifications and how to act. This is particularly important in Primary Care (PC).
Aim:
Determine frequency of CVs in PC.
Assess protocol.
Methodology:
Scope of activity: Serranía Healthcare Management Division.
Study population: outpatient laboratory tests (>850,000 tests/year).
Study period: 2012-2016.
Intervention: Monitoring CVs of glucose, creatinine, potassium, sodium, calcium, lithium, digoxin, hemoglobin and platelets.
Protocol and follow-up: Laboratory verifies CVs; it first notifies patient's healthcare center via telephone; if unable to make contact, it notifies the closest emergency department; if unable to make contact, it notifies local police.
Results: 100% compliance with protocol. 410 patients contacted over 5 years, annual mean (M): 82. CV Frequency: 0.01%. Main problems: Hemoglobin (M=30.4%), Glucose (M=22.4%) and Sodium (M=8.4%). No incidents for lithium or pH tests. The communication channel with PC was improved, with personnel designated in charge after hours.
Conclusion:
A protocol for CVs in PC is necessary, particularly in isolated areas. When faced with at-risk patients, it guarantees communication, minimizes response times and provides greater safety.
Though the frequency of CVs seems insignificant, the complexity of accessing healthcare facilities when far from a hospital, when patients are at home and often outside of working hours, makes having a strategy to address these cases necessary.

7 Sep 2017,16:05-17:00 (NA094) Poster

Experiences of Patient Safety Activities of Rapid Response Team for First Year

Sulhee Kim, Eunjin Yang, Jeongeun Park, Sangmin Lee, Jinwoo Lee, Hannah Lee, Hyunjoo Lee, Seungyoung Oh, Hogeol Ryu, Sangbae Go
SEOUL NATIONAL UNIVERSITY HOSPITAL, South Korea

[Objectives]
Rapid response team (RRT) is becoming an essential part of patient safety by the early recognition and management of patients on general hospital wards. In August 2015, this hospital launched the RRT for 21 surgical wards. This study aimed to compare the activities and performances of RRT between the former 6 months (period of public relations and settlement of RRT, hereinafter "A Period") and the latter 6 months (mature period of RRT, hereinafter "B Period") during first year.

[Methods]
This hospital is a tertiary care university hospital. The RRT of this hospital runs for 12 hours in weekdays.
The RRT is activated in both ways 1) when bedside medical staff call for or 2) by proactive rounding conducted especially for high risk patients in wards.
The Team compared occurrence rate of preventable CPR and unscheduled admission to ICU between A Period and B Period.

[Results]
RRT activated 318 times in A Period, whereas 357 times in B Period. Unscheduled admission to ICU was 5.87 cases per 1,000 admissions in A Period, whereas B Period was 6.26 cases, and the ICU length of stay (LOS) was 7.65 days in A Period, whereas in B Period was 5.54 days. Proportion of preventable CPR was 73% (8/11) in A Period, whereas 50% (3/6) in B Period.

[Conclusion]
Comparing both period, the team found that LOS and proportion of preventable CPR was reduced by 27.6% and 23% respectively. Given the above, we found that RRT may contribute to the promotion of patient safety.

7 Sep 2017,16:05-17:00 (NA152) Poster

Safety in Medical Environment – Discussion on the Prospective Vulnerability Analysis Results and Risk Management Results

WEN CHUN TSAI,YA LING CHEN, PEI YING CHEN, YU WEN SHIH, SHU FEN CHOU
Department of Nursing, En Chu Kong Hospital, Taiwan

Background: Hospital environmental safety is an important issue. Hospitals have annual fire emergency drills, but there are a few discussions on the analysis of effective vulnerability assessment and their risk management. Purpose: To use and understand prospective vulnerability analysis results and its impact towards risk management results. Method: In 2016, vulnerability analysis was introduced with the participation of 566 medical staff and occupational safety members. According to event incidence rate*impact level*response preparation level = risk assessment analysis results, prevention strategies were planned. With the hospital risk (≧ 20): disaster drill program and practices shall be planned. Partial risk (19-3): table top exercise shall be implemented; unit control (≦2): relevant operation standards based on each unit shall be established. Results: Based on the vulnerability analysis results of the 17 nursing stations, there were 10 wards for fire incidents, 1ward for earthquake, 2 words for night fire incidents, Obstetric ward for baby robbery, Chinese medicine Outpatient clinic for Emergency evacuation exercises and Emergency room for violent incident in terms of the hospital risk (≧20).Conclusion: By using the prospective vulnerability analysis results, High risk events change , educational trainings and drills shall be fortified so as to enhance the results of risk management, to keep patients safe and to minimize the hazards.

7 Sep 2017,16:05-17:00 (NA059) Poster

Communication between nursing students and nurses during practicums

Yukiko Kai1), Keiko Murakami2), Yuriko Ohkawa1)
School of Nursing, Faculty of Medicine, University of Miyazaki, Japan

Key words: nursing students, nurse, clinical training, communication, safety, questionnaire

Objectives: We examined the actual circumstances of poor reporting, communication, and consultation in communication between nursing students and nurses.

Methods: A questionnaire survey of nursing students was conducted to examine the times, situations, and reasons for poor communication that negatively affected patients; coping strategies; and how to address such problems in the future. Simple tabulation was performed for the times and situations, and classification was performed for the reasons, recommendations, and how to address such problems in the future.

Results: Of 53 nursing students, 44 felt there was poor communication between nursing students and nurses, and 18 responded that this had a negative effect on patients. Poor communication occurred most frequently in the third year, and the most common situation in which it occurred was reporting. The reasons given for poor communication were “personal relationships with nurses” and “factors related to students.” Specific situations indicated in the responses were “factors related to nurses,” “the practicum environment,” “factors related to students,” and “effects on patients.” The coping strategies mentioned in the responses were “prompt students to act on their own initiative,” “form personal relationships with nurses,” and “not possible to address the problem.” Mentioned as ways to address such problems in the future were, “an instructional attitude that shows respect for students” and “the realities of instruction.”

Discussion: The atmosphere of the busy medical setting has given rise to inadequacies in nursing student reporting, communication, and consultation, which has affected patients. As a result, nursing students realized the importance of communication.

7 Sep 2017,16:05-17:00 (NA081) Poster

Safety assessment of using preliminary formulation for preparing antitumor drugs

N.Mochizuki, D.Kano, M.Morimoto, N.Yoshino, M.Tanaka, M.Yamaguchi
National Cancer Center Hospital East, Japan

We provide approximately 250 anti-cancer drug injections per a day; therefore, by preparing 5-FU in syringes a day before injection, we are abl
e to efficiently prepare anti-cancer drugs. However, safety of the preparation is not sufficiently studied. To verify sterility of the prefilled preparation, we conducted Medium Filling test.
METHODS: We filled Medium of Signal Blood Culture System (Oxoid Ltd., UK) into a 20 mL vial similar to 5-FU product in the class 100 sterile isolator. In the same manner as the preliminary preparation of 5-FU, 50 mL of the medium was transferred from the prepared vial by a robot or human operation to a syringe. The syringe filled with the medium was stored at 4℃. We injected 10 mL of the medium from each syringe into the Signal Blood Culture System on days 4, 7 and 14 after storage, and these samples were cultured at 37 ° C and tested by Medium Filling test
Results： Each day 10 samples were examined, but no growth of bacteria was observed in all samples including robot regulated products and human preparations.
Discussion: Microbiological safety of pre-conditioning of the syringes from the product vials is not problematic both by robot and human preparations to improve work efficiency, and it is safe to store in the syringes for up to 14 days. We will continue to monitor regularly to ensure reliability, and we would like to conduct efficient and safe preparations of anti-cancer drugs.

7 Sep 2017,16:05-17:00 (NA070) Poster

Potential drug therapy issues for the elderly: an insight based on nation-wide prescription audit in primary care

Khalid Ahmed Jassim Al Khaja, Sindhan Veeramuthu, Reginald P. Sequeira
Arabian Gulf University, Bahrain

Background The elderly are vulnerable for developing adverse drug events due to both age-related comorbidities and polypharmacy practice.
Objective This primary care prescription audit evaluated the drug-drug interaction (DDI) potential and drug therapy-related problems (DRPs) that may be expected in elderly patients.
Methods A nationwide audit of 2090 prescriptions issued to patients aged ≥ 65 years with hypertension or both diabetes mellitus and hypertension, in Bahrain.
Results The mean age (± SD) of these patients was 72.1 ± 6.0 (54.1% female). The total number of drugs prescribed was 12,602 (range 1-16; mean 6.0 ± 2.5 drugs per patient). Approximately one-quarter of the patients were on acid-suppressing drugs (ASDs), and 95% of these patients received ASDs on a long-term basis (mean 4.0±1.0 months). Twenty percent (211/1073) of diabetic patients received concomitant metformin and ASDs, both of which may produce vitamin B12 deficiency. Lipophilic statins such as omeprazole/esomeprazole that interfere with clopidogrel efficacy were prescribed in 63.8% (30/47) and 30.8% (4/13), respectively. Other potential inappropriate prescriptions included: β1 antagonists with insulin(s), glyburide, or their combinations (3.2%; 34/1073); paracetamol >4 gm/day (1.1%; 22/2090); indapamide with QT prolonging drugs (0.9%; 19/2090); cardioselective β1 antagonists in patients with airway diseases (0.8%; 16/2090).
Conclusions The range of DDIs and DRPs expected suggests mild to hazardous ADRs potential for many prescriptions issued to elderly patients in primary care. Interventions are needed to decrease the potential adverse drug event risks that have the potential to compromise elderly patient safety.

Key words: drug-drug interaction, drug-related problems, prescriptions, elderly, primary care, Bahrain

7 Sep 2017,16:05-17:00 (NA087) Poster

The current status of and attitudes towards using a pregnancy-related risk self-assessment scale among Japanese females who gave birth in high-order health care institutions

Kyoko KANAMORI, Kumiko IWATANI, Miwa IZUHARA
Kyoto Koka Women's University, Japan

Aim: This study aimed to investigate the current status of using "pregnancy-related risk self-assessment scale" (Score) among pregnant females, and identify their attitudes towards its use.
Methods: The subject is a woman delivered at the perinatal center in 2013.
Score and an originally developed questionnaire were distributed to the subjects on the third day following childbirth or later, and the results were collected. The survey items included the attributes of the subjects, pregnancy risk scores, utilization of Score, their attitudes towards the choice of a place for childbirth and Score, and its utilization for the next childbirth. The descriptive statistics and $\chi 2$ test were conducted using SPSS Ver.21. (Ethical review: September 2012, No. 12)
Results: The response rate was 80.5% (n=392), mean age was 32.5 ± 4.9, and 44.1% (n=173) gave birth for the first time. The subjects in all risk groups responded that they were aware of the necessity of Score (n.s.), and they viewed it as a useful reference (n.s.). However, only 31.6% (n=115) agreed to use it again during the next pregnancy. According to age groups, subjects aged between 35 and 39 years old were more likely to view it as a useful reference (*) and use it again during the next pregnancy.
Conclusion: Despite some differences between age groups, the females recognized Score as a useful tool to understand their risk levels. However, they had negative attitudes towards the use of Score as a tool to choose a place for childbirth.

7 Sep 2017,16:05-17:00 (NA139) Poster

Influence of Teamwork Perception and Satisfaction of Intra-organizational Communication on Safety Control

Kyoung Ja Kim
Hannam University, South Korea

OBJECTIVE: To explore the influence of teamwork perception and satisfaction of intra-organizational communication on safety control of clinical nurses.
BACKGROUND: Safety control had been known as a factor of clinical safety behaviors by nurses. Positive team work and high satisfaction on intra-organizational communication could be an important influencing factor for the safety control of nurses.
METHODS: A cross-sectional survey design was used. The study involved nurses working in a tertiary university hospital having over 1,000 beds, located in a city, over 1.2 million population, in South Korea. The ratio of number of number of beds to nurses ranged from 2.0 to 2.5. Head nurses, and those with < 3 months of work experience were excluded. Nurses who worked in the general ward, intensive care unit, emergency room, operation room, and recovery room were selected. The structured questionnaire was administered to 149 nurses and 143 questionnaires were returned.
RESULTS: Nurses' perception of teamwork and satisfaction of intra-organizational communication were positively correlated with safety control. A regression model with clinical career, teamwork and satisfaction of intra-organizational communication against safety control was statistically significant. The regression model explained about 31.9% ($F=21.25$, $p<.001$) of safety control. And clinical career ($\beta=.29$, $p<.001$), teamwork perception ($\beta=.29$, $p=.003$), satisfaction of intra-organizational communication ($\beta=.21$, $p=.026$) were the influencing factors on safety control of clinical nurses.
CONCLUSIONS: Improving nurses' safety control can be achieved with a broad approach that includes improvements in teamwork and intra-organizational communication.

Abstract

8 Sep 2017 Oral

8 Sep 2017, 9:30-10:00 (NA162) Oral

The management of dermal filler complications - Aesthetical Medicine Department of the hospital St. Giovanni Calibita - Fatebenefratelli in Rome

Gloria Trocchi, Emanuele Bartoletti
Aesthetical Medicine Department of the hospital St. Giovanni Calibita - Fatebenefratelli in Rome, Italy

Dermal fillers are used for the correction of skin defects or wrinkles. They are medical device, not subjected to the preliminary drug regulation, even if they are not completely inactive substances. Fillers can determine adverse events, related not only to their chemical – physic and biological characteristics, but even to unexpected reactions of the organism guest. The growth of more different dermal filler in the market and of the operators of the sector has determined an increase of the incidence of filler complications. This has made necessary to constitute a center of excellence that represents a point of reference on the territory for the management of these complications.

8 Sep 2017, 10:00-10:30 (SL: NA075) Oral

The Role of Nurse Leaders in the Promoting the Safe Integration of Internationally Educated Nurses into Canadian Hospitals

Prof. Linda McGillis Hall, PhD, FAAN, FCAHS
University of Toronto, Canada

Objectives:
Considerable literature exists on the immigration of internationally educated nurses (IENs) in other countries, but little information exists to guide nurse leadership, and in particular, nurse leaders role in the development and implementation of policies that promote the safe integration of IENs in Canada. The objective of this study was to gain a better understanding of the important role of nurse leaders in developing and implementing a key workforce change – specifically employment practices that promote the successful integration of IENs into healthcare work environments in Canada, within the context of quality patient care.
Methods:
A comparative research design of a random sample of IENs, Canadian educated nurses (CENs) and nurse leaders from Canada was conducted. The survey gathered information on professional/demographic characteristics of IENs and CENs, and leadership initiatives implemented by nurse leaders including employment patterns, recruitment incentives utilized, workplace integration mechanisms employed, and long-term methods for retention of IENs proposed. The sample was comprised of 2,107 IENs, 1,172 CENs and 255 nurse leaders.
Results:
Some differences were noted between IENs and CENs on perceptions of work experiences and of work here in Canada. In addition, nurse leaders described a variety of innovative models for recruiting and retaining IENs to their work settings. As well, generous orientation and mentorship strategies were highlighted along with mechanisms to reduce many of the known barriers to IEN integration into hospital work settings. Supports in place for ongoing IEN education as well as strategies aimed at successful integration of IENs into work settings were highlighted. IENs had statistically significantly higher perceptions of satisfaction with nursing as a career and their current job, quality of care provided, amount of orientation and ongoing opportunities provided for updating their skills, than their Canadian-educated counterparts.
Discussion:
This study provides the first information on experiences in hiring and employing IENs; leadership strategies used to integrate IENs into the work environment; and perceptions of IEN competencies, contributions to the work environment, and quality of care in the Canadian context. The study uncovered new information on successful ways to integrate IENs into work settings.

8 Sep 2017, 10:30-10:50 (NA071) Oral

THE USE OF MEDICAL SIMULATORS MAY LEAD TO A SIGNIFICANT REDUCTION IN HEALTH CARE COSTS

G. Halmerbauer1, N. Kamptner, A. Schrempf, C. Ausch
University of Applied Sciences, AUSTRIA

Objectives: We hypothesized that a reduction of surgical complications results in a cost reduction of medical treatment. Primary aim was to identify intra- and postoperative technical complications and documented irregularities in the operative reports, which are caused by surgical technique. Secondary aim was to identify cost effects caused by these complications.

Methods: Records from 1,686 patients operated in eight hospitals in upper Austria were reviewed. Group 1 (n=250) consisted of patients with technical complications and/or irregularities in the operative reports and group 2 (n= 1436) consisted of patients with non-technical complications or without complications and/or irregularities in the operative report. All patients with surgery for inguinal hernias, appendicitis, the gallbladder and the thyroid were included. Variables were analyzed using regression analysis.

Results: Costs of laboratory and radiological tests (p<=0.001), length of operation (p<=0.02) and length of stay (p<=0.001) were significantly higher in group 1 compared to group 2. Diagnostic Costs in group 1 were 441.5 euros [238.3; 645.1] higher than the costs of group 2. Length of stay (1.2 days [0.6; 1.8]) and length of operation (4'57'' [42''; 9'13'']) were significantly longer in group 1 than in group 2.

Conclusion: Our results demonstrate a potential for cost reduction. As the routine use of medical simulator can lead to a reduction in technical complications, there might be a potential for cost reduction in the health care system. Hence, these results might serve as a basis for an increased use of medical simulators and a training of surgeons on a regular basis.

8 Sep 2017, 10:50-11:10 (NA088) Oral

An application of classification methods on clinical data for retrospective detection of patients with complications

R. Haslinger (1), G. Halmerbauer(1), H. Wagner(2), C. Ausch(3)*
(1)Department of Process Management and Business Intelligence, University of Applied Sciences Upper Austria, Steyr
(2)Department of Applied Statistics , Johannes Kepler University, 3OÖ. Gesundheits- und Spitals-AG, Linz, Austria

Objectives:
The aim of this study was to compare different classification methods for the retrospective detection of patients with one or more surgical and/or medical complications.

Methods:
Data from hospital data bases of eight clinics in Upper Austria were combined with data collected by data nurses from handwritten patient documentation. Complication (yes/no) was selected as the target variable. Patients undergoing acute appendectomy (n= 1341), acute and elective cholecystectomy (n= 1307) and elective inguinal hernia repair (n = 1574) were included into the study.
Data on services received by the patients was combined with 45 parameters concerning patient risk. For each of the three datasets three different methods, logistic regression, boosting for generalized linear models (boosting) and classification trees (ctree) were applied to detect patients with complications.
To assess the classification performance of the models, positive predictive value (PPR), rate of positive predictions (RPP) and sensitivity were compared after the application of the models on additional test data. In addition to predictive performance the number variables in the final model is also an important criterion for choice of the final model as more variables need more efforts on data collection and preparation.

Results: A comparison of sensitivity, PPV and RPP showed that models selected by ctree perform better than the classical logistic regression and boosting models. With PPVs between 16 % and 30 %, sensitivities from 80 % to 95 % and RPPs around 30 %. Additionally the ctree involved the smallest number of variables going from 6 to 9.

Conclusion: Application of our classification tree models on existing data can save time and costs for the identification of patients with a history of surgical and medical complications in surgery.

8 Sep 2017, 11:10 –11:30 (NA015) Oral

Clinical Leadership in Establishing General Practitioner Accreditation for Minor Surgery: A National Pilot Study

Dr Ailís ní Riain, Dr Claire Collins, Dr Tony O'Sullivan
Irish College of General Practitioners, Ireland

Objective
Carrying out minor surgery procedures in the primary care setting is popular with patients, cost effective and delivers at least as good outcomes as those performed in hospital. Our objective was to develop a valid, robust, workable accreditation system for general practitioners (GPs) undertaking community based surgery in Ireland where no mandatory accreditation currently exists.
Method
A majority of GPs was included at all stages of the project. The Steering Group had a majority of GPs with relevant expertise, and representation of all other actors. The GP network contributed to each stage of the project. The project lead was a GP with minor surgery experience. Quantitative data was analysed using Predictive Analytic SoftWare (PASW). Krueger's framework analysis approach was used to analyse qualitative data. The ICGP Research Ethics Committee provided ethical approval.
Results
Twenty four GPs were recruited to the GP Network. Ten pilot standards were developed addressing GPs' experience and training, clinical activity and practice infrastructure and tested, using information and document review, prospective collection of clinical data and a practice inspection. A multi-modal evaluation was undertaken. Nine GPs achieved all standards at initial review, 14 successfully completed corrective actions and one GP did not achieve the standard. Standards were then amended to reflect findings and a supporting framework was developed.
Conclusions
This project demonstrates that it is possible to develop robust quality standards for community based minor surgical procedures in the real-life setting over a short timeframe. Clinical leadership promotes mutual support, ensures relevance and promotes buy-in.

8 Sep 2017, 11:30-11:50 (NA100) Oral

Team Briefing - Changing the Focus of Surgical Safety Checklists

Kristine Wyatt
Kyneton District Health, Australia

The intention of the World Health Organisation Surgical Safety Checklist is to improve team communication and team culture in relation to patient safety. They are intended to be modified to suit organisational needs after appropriate risk assessments have been completed. A growing body of evidence links teamwork in surgery to improved outcomes, with high-functioning teams achieving significantly reduced rates of adverse events.
Aviation safety practices are often cited as examples of improving safety through checklists. When it comes to checklist implementation, it is important to recognise that aviation checklists are integral to the normal workflow. The aircraft does not stop while the checklist is completed, and the timing of checklist completion is arranged so that it does not conflict with other essential flight activities. To that end, the checklist does not impose an additional burden or workload, but is actually perceived by aircrew as something that makes the flight easier. In contrast, the surgical safety checklist is performed before the case can begin, so stands independently of the workflow. To that end, the surgical safety checklist is likely to be seen as something additional.
Our unit has an exemplary safety record and a culture of strong commitment to patient safety in a high risk and complex environment. A trial was proposed that did not remove any essential patient safety checks but conducted the checks at more appropriate times, to reduce the risk of delays and cancellations and to encourage active participation in the critical elements of patient safety checks.

8 Sep 2017, 13:00-13:20 (NA003) Oral

Integrating Nursing Informatics to Improve Patient-Centered Care

Pi-Chi Wu
Department of Nursing, Chiayi Chang Gung Memorial Hospital, Taiwan

Background: The ability to provide immediate medical service in outpatient departments is one of the keys to patient satisfaction.
Objectives: This project used electronic equipment to integrate nursing care information to patient care at a blood pressure diagnostic counter. Through process reengineering, the average patient waiting time decreased from 35 minutes to 5 minutes, while service satisfaction increased from a score of 2.7 to 4.6.
Methods: Data was collected from a local hospital in Southern Taiwan from a daily average of 2,200 patients in the outpatient department. Previous waiting times were affected by (1) space limitations, (2) the need to help guide patient mobility, (3) the need for nurses to appease irate patients and give instructions, (4), the need for patients to replace lost counter tickets, (5) the need to re-enter information, (6) the replacement of missing patient information. An ad hoc group was established to enhance patient satisfaction and shorten waiting times for patients to see a doctor. A four step strategy consisting of (1) counter relocation, (2) queue reorganization, (3) electronic information integration, (4) process reengineering was implemented.
Results: Implementation of the developed strategy decreased patient waiting time from 35 minutes to an average of 5 minutes, and increased patient satisfaction scores from 2.7 to 6.4.
Conclusion: Through the integration of information technology and process transformation, waiting times were drastically reduced, patient satisfaction increased, and nurses were allowed more time to engage in more cost-effective services. This strategy was simultaneously enacted in separate hospitals throughout Taiwan.

8 Sep 2017, 13:20-13:40 (NA005) Oral

GENETIC EVENTS IN CHRONIC LYMPHOCYTIC LEUKEMIA

Aurelian Udristioiu, Manole Cojocaru
Emergency County Hospital & , Faculty of Medicine, Titu Maiorescu University, Romania

Aim of this study is to present the latest researches in the field of molecular medicine, in terms of Chronic Lymphocytic Leukemia (CLL), emerged from the P53 gene deletion in human lymphoma genome.
Method
In recent years proved that the best technique in the investigation of malignant lymphocytes is the Fluorescence in situ hybridization (FISH). This method is used as an alternative to chromosomal banding, a conventional application in molecular medicine.
Previous results:
In the literature it was registered, in previous years, on an international study, conducted on 109 cases of CLL, 79 cases (72.5%) who had more genetic abnormalities: the remaining 30 cases (27.5%) had normal results, using FISH technology. The majority of patients, 67% (53.79) had a single anomaly and the remaining 33% had two or three genetic abnormalities. The chromosomes 14q32 /17p translocations in LLC genome, which appeared similar to some common, had demonstrated abnormalities involving IGH gene, located on chromosome14q32.
Discussion
Recent, endogenous somatic gene therapy research is a basic of trial clinical and therapeutic trial. The DNA is used to treat a disease arising as a result of mutations in chromosomal regions. In the past few years, this method has been included in the treatment of CLL, acute lymphocytic leukemia, [ALL], or multiple myeloma [MM].
Conclusion
The frequencies of P53 gene mutations and deletion in CLL can be categorized as individual biomarkers in proteomic and genomic profile for this type of leukemia that can be implemented in targeted patient treatment of personalized medic
Keywords: Gene P53, chronic lymphocytic leukemia, Apoptosis, fluorescence in situ hybridization, Cancer

8 Sep 2017, 13:40-14:00 (NA049) Oral

Utilization Management Of Platelets Units Using Lean Six Sigma Methodology

ola magdy abdel hameed torky
Children's Cancer Hospital Egypt 57357, Egypt

Business Case/Impact : As CCHE vision , mission & strategic goals for patient centered by providing him with best practices & make the resources available all time Free Of Charge , platelets is a finite supply & process improvement should be to increase availability
Descriptive and retrospective hypothesis test case control design using lean six sigma tools
SIGMA LEVEL = 1.5
Problem /Opportunity Statement :
1- Discrepancy Between Ordered & Dispensed Platelets Units
2-Overutilization of platelets
3-Incompatability between platelets order & hospital guideline
Goal Statement :
1- Track Discrepancy Between Platelets Units Ordering & Dispensing & effect on ROI (return on investment) & inventory management
2- How to make best utilization of resources with best clinical outcome
3-Evaluate current method for platelets ordering using different statistical tools
4-Opportunity for improvement using lean & poka yoke concept
Project Scope:
Process start point: Physician orders platelets
Process end point: Blood bank personal dispenses platelets
No clinical judgment on reason of order & dispensing process
Long term data collection : 1 month
Data source : Electronic medical records (powerchart & AppBar blood bank)
MEASUREMENTS
Discrepancy between number of units ordered & dispensed
Platelets order compliance with platelets transfusion guideline
Cost benefit analysis of wielding process
POPULATION CRITERIA
Exclusion Criteria : Inpatient (ICU ,Stepdown , OR & BMT) & ER
Inclusion Criteria : Inpatient (solid tumor & hematological diseases)
GROUP A :
Platelets Count Is $\leq 10*10^3$
GROUP B :
Platelets Count Is $>10*10^3$ & $\leq 20*10^3$
GROUP C :
Platelets Count Is $>20*10^3$ & $\leq 50*10^3$
GROUP D :
Platelets Count Is $>50*10^3$
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8 Sep 2017, 14:00-14:20 (NA041) Oral

Preventing and managing hospital acquired pressure ulcers

Hany Mohamed, Mohamed kheder, sayda medany, ayman Mohamed and wesal skaker
Children's Cancer Hospital Egypt 57357, Egypt

Background: A pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. In pediatric oncology patients, it's highly critical to acquire pressure ulcers due to low immunity which may lead to sepsis. Many factors affect pressure ulcers incidence in pediatric oncology patients as poor nutritional status, chemotherapy treatment, radiotherapy and medical devices. So starting to detect high risk patients to acquire pressure ulcers then using preventative precautions as skin care bundles, evidence based supplies to decrease pressure on skin and establish team to be responsible for assessing, managing and evaluating skin status, to stop incidence of ulcers. Aim: preventing and managing pressure ulcers. Setting: children cancer hospital Egypt (CCHE) 57357. Sampling: convenience sampling technique for all high risk patients to acquired pressure ulcers (No. 266 patients). Improvement methodology: Plan-Do-Check-Act (PDCA). Results: significant decreasing of pressure ulcers incidence number and improvement of controlling ulcers.

8 Sep 2017, 14:20-14:40 (NA153) Oral

The Enhancement of ER Workplace Safety as to Reduce the Turnover Rate of the Nursing Staff

WEN CHUN TSAI, YU WEN SHIH, YU HUA CHOU
Department of Nursing, En Chu Kong Hospital, Taiwan

Background : In February 2013, an emergency nurse was bitten by a patient with AIDS. There were 27 (81%) personnel who wanted to quit their job because of this reason. Purpose: To enhance the ER workplace safety as to reduce the turnover rate of the nursing staff. Method: A cross - sectional study is used for a convenient sampling. 33 paper questionnaires were delivered in May 2013 and 33 effective questionnaires were recycled. Result: As indicated by the nursing staff, there were 27(81.8%) abusers who were relatives and friends of the patients, 23(69.7%) were patients .30 (90%) people consider that the safety condition of the workplace still needs improvement. The satisfaction degree of the workplace has 9%. What shall be improved: 28(84.9%) people consider the collocation of a 24hr. security guard; 20(62.9%) for the collocation of alarm system; 19(58.3%) for a police hotline; 18(53.8%) for “anti-violence posters”; and 14(42.4%) for a clear division between the treatment area and waiting area. During September 2013 – June 2014, ER software and hardware facilities were implemented based on the aforementioned feedback of the nursing staff.(1) Set up 24-hour security staff(2) Nursing station installed sirens(3) Establish the connection between the police equipment(4) Emergency room posting anti-violence posters(5) Treatment area and waiting area set up security door. Until July 2014, only three (9%) resigned. The satisfaction degree of the workplace has from 9% to 80%.Conclusion: The participation of the ER nursing staff in the enhancement of workplace safety can effectively reduce the turnover rate.

8 Sep 2017, 14:40-15:00 (NA036) Oral

The usefulness of After Action Review system to improve the quality of debriefing in medical system

Hitoshi Yanaihara, Naoto Okada, Satoru Utsunomiya, Toshiyuki Narumi, Kanji Kabasawa, Sakae Otani, Masayasu Aoki Yuichiro Yana, Eiji Morita, Yasuto Omura, Hidetomo Nakamoto
Saitama Medical University, Japan

Debriefing is an important step to retrieve suggestions from incidents. However, it could be biased to find the problem if the debriefing would be held in company. After Action Review(AAR) is a structured debrief process for analyzing the training, used by US military services. This is widely used in business as a management tool. We are trying to use this system to elucidate the process of incidents in medical field.

Method
The director of the department of medical management was the AAR facilitator in all sessions. The facilitator managed the discussion which is focusing on what happened, why it happened, and how it can be done better by the participants or other personnel in charge within 2 hours. Discussion was held between the personnel only directly involved to the events. Every session was evaluated by participants using score sheet.

Result
Initial evaluation by participants showed unfavorably received in the discussion itself and the role of the facilitator. The role of facilitor has been accepted after a couple of sessions, but the participants has not been satisfied to show their own opinion.

Discussion
AAR is very sophisticated implement to lead the consensus, because it shows the direction of discussion very clearly. However, the choice of facilitator and its educational system has not been clear currently in our medical system.

8 Sep 2017, 15:00-15:20 (NA064) Oral

The relationship between working hours and dietary habit and weight gain during the pregnancy period

Eri Abe, Minatsu Kobayashi, Kohei Ogawa, Katsunori Cha, Naho Morisaki, Takeo Fujiwara
Ohtsuma Women's University Japan

【Background and Objective】In recent years, both women’s labor and the population of double income rate has risen in Japan. A survey, Time Use and Leisure Activities in 2011, reported that those who work tend to have less time to do housekeeping compared to those who do not work. In this research, we investigated the influence that labor has on diet and weight gain during the pregnancy period. 【Method】The subjects were 149 pregnant women who were recruited at the National Center for Child Health and Development (NCCHD). Based on the amount of working hours per week, the subjects were divided into no work (n=80), part-time (n=22), and full-time(n=47) groups.Using medical examination data, a 3-day dietary record and weight gain during pregnancy we assessed their nutrient and food intake. Based on appropriate weight gain during pregnancy according to the BMI before the pregnancy by the Ministry of Health, Labour and Welfare we evaluated their weight gain, ”appropriate”, “high”, and “low”. Tukey’s HSD analysis and chi-square test was used to compare the three groups.
【Result】The part-time group had significantly higher intake of energy, compared with the full-time group (p=0.0365). And the part-time group had significantly higher intake of fat than the other groups ($p<0.05$). Compared to their weight gain, the ratio of “appropriate” was significantly high in the part-time group (p=0.0182), and the ratio of “low” tended to be high (n.s).【Conclusion】This research indicated that the energy load during pregnancy was supplemented with fat in the part-time group, and this prevented low weight gain.

8 Sep 2017, 15:20-15:40 (NA017) Oral

Development the Patients Safety and Quality Management Feedback Support System for the purpose of reduction in task load of Patients Safety Managers

Tatsuya Kitano
Seijoh University, Health Care Management Course,Faculty of Business Administration/Graduate School of Health Care Studies,Patients Safety & Quality Management , Japan

Various investigation results including [Investigation report for current situation of clinical safety management system and safety management training] (Kitano and others, Aug. 2011), revealed that there is a gap by each hospital in terms of clinical safety managers' task, positioning within an organization, classification by level for an accident and its analysis method, where issues resides in safety planning by clinical safety managers within each hospital. Taking those investigation results into account, I, hereby, report new method of re-structuring clinical safety management system including re-organization within hospital to prevent medical accidents, the way of clinical safety management training program should be, development of Patients Safety and Quality Feedback Support System to reduce work load of clinical safety managers. This mechanism provides 1. KYT (Kiken Yosoku Training), improvement in securing patient monitoring system since hospitalization, 2. Forestall action planning, 3. Inspection check sheet for clinical quality and safety improvement, 4. Visualization of improvement indicator to support clinical safety activity, leading to decrease of a number of medical accidents. Also, with deployment of "Patients Safety and Quality Management Feedback Support System", clinical safety managers' significant workload for data aggregation of medical accident and analysis (account for 54% of their work) are reduced. Instead, managers can spend more time on in-hospital patrol, clinical safety education and organization enhancement, etc. With that, I hope I will find further significance in re-organization of clinical safety management system for the purpose to decrease medical accidents, etc. So I believe this research is valuable.

8 Sep 2017, 15:40-16-40 (NA050) Poster

Utilization Management Of Platelets Units Using Lean Six Sigma Methodology

Ola Magdy Torky ,Shaimaa El Meniawy
Children's Cancer Hospital Egypt 57357, Egypt

Business Case/Impact : As CCHE vision , mission & strategic goals for patient centered by providing him with best practices & make the resources available all time Free Of Charge , platelets is a finite supply & process improvement should be to increase availability
Descriptive and retrospective hypothesis test case control design using lean six sigma tools
SIGMA LEVEL = 1.5
Problem /Opportunity Statement :
1- Discrepancy Between Ordered & Dispensed Platelets Units
2-Overutilization of platelets
3-Incompatability between platelets order & hospital guideline
Goal Statement :
1- Track Discrepancy Between Platelets Units Ordering & Dispensing & effect on ROI (return on investment) & inventory management
2- How to make best utilization of resources with best clinical outcome
3-Evaluate current method for platelets ordering using different statistical tools
4-Opportunity for improvement using lean & poka yoke concept
Project Scope:
Process start point: Physician orders platelets
Process end point: Blood bank personal dispenses platelets
No clinical judgment on reason of order & dispensing process
Long term data collection : 1 month
Data source : Electronic medical records (powerchart & AppBar blood bank)
MEASUREMENTS
Discrepancy between number of units ordered & dispensed
Platelets order compliance with platelets transfusion guideline
Cost benefit analysis of wielding process
POPULATION CRITERIA
Exclusion Criteria : Inpatient (ICU ,Stepdown , OR & BMT) & ER
Inclusion Criteria : Inpatient (solid tumor & hematological diseases)
GROUP A :
Platelets Count Is $\leq 10*10^3$
GROUP B :
Platelets Count Is $>10*10^3$ & $\leq 20*10^3$
GROUP C :
Platelets Count Is $>20*10^3$ & $\leq 50*10^3$
GROUP D :
Platelets Count Is $>50*10^3$
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Abstract

8 Sep 2017 Poster

8 Sep 2017, 15:40-16-40 (NA051) Poster

Assess The Culture Of Patient Safety Through Humpty Dumpty Fall Scale (HDFS) Evaluation

Ola Magdy Torky ,Shaimaa El Meniawy
Children's Cancer Hospital Egypt 57357, Egypt

Introduction:-
Child fall is a very serious event and is being recognized as an indicator of patient safety for health care organizations.
As children cancer hospital in Egypt(CCHE) 57357 vision, mission and strategic goals for patient centered pain alleviation, protect patient from fall is one of international patient safety goals (IPSGs).
Nurse plays an important role in culture of patient safety through her awareness about fall prevention program.
Literature review:
1- The current lack of supportive research to validate HDFS.
Further studies to validate the reliability and validity of the fall risk screening tool used at Children's Hospital will improve the efficiency and effectiveness of care and promote a safe environment for pediatric patients.
Significance of the Study:-
1- Protect patient from fall is one of international patient safety goals IPSGs (Goal NO 6)
, Humpty Dumpty fall scale (HDFS), A tool used to assess fall risk through:
Humpty Dumpty Tool sensitivity & specificity.
The effect of individual approach on fall scoring.
The effect of process (scale related factors) on fall scoring.
Nursing questionnaire.

2- HDFS recognizes the predictive ability to identify hospitalized children at risk for fall.
Aim of the study:
1-Achieve substantial increases in reliability of HDFS over present levels of patient safety regarding fall.
2-Promote a culture of patient safety through individual approach.

Research Questions:-
1- Dose HDFS address a fall prediction?
2-Evaluate An Existing Fall Prevention Program:
A-In the pediatric acute care setting, what is the sensitivity & specificity of the Humpty Dumpty Fall Assessment Scale (HDFS) in predicting hospitalized children's fall risk?
B-How can Humpty Dumpty Falls Scale (HDFS) Adapt Culture Of Patient Safety?
C- How dose nurse evaluate HDFS?

Research Methodology:-
A:-Research Design
Descriptive and Retrospective hypothesis test case design will be utilized for this study.
Using lean concept six sigma methodology tools in improvement process through problem define, measure, analysis, improve & control.
B:-Subjects:
Pediatric inpatient undergoes *invasive procedure at procedure room under general anesthesia & stay for at least 12 hrs before discharge (2 nursing shifts)
*invasive procedure (CSF, BM Biopsy & BM Aspiration)
Collected Data: *1st Ongoing Assessment (at the beginning of morning shift)
* Post Procedure Assessment (at recovery room)
* 2nd Ongoing Assessment (at the beginning of night shift)
*(Electronic assessment form contains fall risk assessment)

Sample size:
Inclusion Criteria:
Pediatric inpatient (Medical)

1- Admitted patient stays for 24 hours (*10AM -**9AM) & undergo invasive procedure with anesthesia
* Start of morning shift
**Start of night shift

Long term data collection : 1 month

Exclusion Criteria:
Outpatient Areas, OR & Inpatient Areas (Critical –Surgical: ICU, Stepdown , Surgical ICU,(Surgical wards :3D,3E) & BMT)

Practice Implications:
1-The HDFS tool, a fall prevention pediatric program fulfills the Joint Commission Patient Safety Goals(Goal No 6), but further research is needed to evaluate the tool sensitivity-specificity.
2- Avoid shortcuts
3-Avoid human subjectivity & errors

Abbreviations:
CCHE: children cancer hospital in Egypt 57357
BM: bone marrow.
CSF: cerebral spinal fluid.
HDFS: humpty dumpty fall scale.
HROs: high reliability organizations.
ICU: intensive care unit.
BMT: Bone marrow transplantation.

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8 Sep 2017, 15:40-16-40 (NA061) Poster

Factors analysis of poor healing wound in negative pressure wound therapy

YEN-HSI, LIN, TING-TING, CHENG, JIUN-LING,WANG
National Cheng kung University Hospital , Taiwan

We often use negative pressure wound therapy for healing impairment after debridement surgery in patients with diabetic foot or decubitus ulcer wound. However, there were some patients developed treatment failures after this procedure. In this retrospective study, we demonstrated treatment course in negative pressure wound therapy and we tried to find the possible causes of treatment failure in these cases.

Material and Method:

We used PUSH tool score to assessment the wound healing and tried to find the factors related to poor healing by a checklist of multidisciplinary team work

Result:

We collected 20 cases (70% of diabetes mellitus) and used negative pressure wound systems in a general medical ward. And 20% (n=4) had treatment failure. Two of them, malnutrition and zinc deficiency may be the main focus of poor healing. And one patient had insufficient position changing at night due to pain intolerance. And one patient closed out negative pressure wound therapy one week later because he developed infection. And the two patients had progressive peripheral arterial occlusive disease and lead to gangrene after wound debridement

Conclusion:

There were many factors related to wound healing promotion. Before using negative pressure wound therapy, we should have a checklist including nutrition status, infection control, wound change dressing education and peripheral arterial occlusive disease treatment. Multidisciplinary team work can help to increase wound healing.

Keyword: wound healing, diabetic foot, pressure ulcer, Negative pressure wound therapy

8 Sep 2017, 15:40-16-40 (NA062) Poster

Evaluation of multidisciplinary management care involved in diabetic wound

YEN-HSI, LIN,, JING-YI, LIN , JIUN-LING, WANG
National Cheng kung University Hospital , Taiwan

BACKGROUND AND PURPOSE:
people with diabetes mellitus had over more than 1.5 million population in Taiwan, and became to the 5th among the top ten leading causes of death。 Diabetic foot and amputation has suffering impact on the personal and activity. Based on evidence, the medical team should be work together to get maximum benefit.
CASE DESCRIPTION AND METHODS:
Wagner ulcer classification with Texas wound system and accepted include wound debridement, documented nutrition care screening(MUST) ,assessment(vitamin defect), fasting sugar control and vassals perfusion screening. This three patients all accepted debridement .Set up negative pressure wound therapy and PUSH tool 3.0 to evaluation.
OUTCOMES:
During diabetic diet education and nutrition plan with monitor blood sugar level had been offered to individualize. The result of three all decrease be hospitalized and cost, and reduce pain sensation and wound healing absolutely were more importantly. A good implementation of multidisciplinary team and wound care nurse were the best role of patient management.
Conclusions
Diabetes wound is a common problem in clinical situation. It is a result in a huge medical expensesand a major challenge The best care bundle should to set up a clinical wound combination multidisciplinary team work and the patient has an individual way of dressing. We should be to have found a wound care plan of check list, that promote further wound healing.
Keywords: combination multidisciplinary care, diabetic foot, negative pressure wound therapy, nutrition intervention, Wangner classification, pressure ulcer scale for healing.

8 Sep 2017, 15:40-16-40 (NA067) Poster

Development and validation of a trigger tool to identify adverse events and no-harm incidents in home healthcare

Marléne Lindblad, Schildmeijer Kristina, Nilsson Lena, Ekstedt Mirjam, Unbeck Maria
Royal Institute of Technology, School of Technology and Health, Stockholm, Sweden

Background Adverse events (AEs) are common and of great concern in healthcare and has been investigated in in-hospital care in a large amount of studies, but to a much lesser extent in home healthcare. A context-specific record review tool for home healthcare has not, to our knowledge, been developed. The aim of the present study was to develop and validate a national trigger tool (TT) to identify AEs and no-harm incidents in home healthcare.

Methods The TT was developed and validated in a stepwise manner, using 1) literature review and multidisciplinary interviews; 2) a five-round modified Delphi process; 3) two-stage retrospective record reviews. Ten teams from Sweden reviewed 600 patient records.

Results Overall, triggers were found 4,031 times in 518 (86.3%) records, with a mean of 6.7 (median 4, range 1−54) triggers per patient with triggers. The total positive predictive value (PPV) for AEs and no-harm incidents were 41.5% (range 0.0−94.1% per trigger) when using 38 triggers. The final TT included 23 triggers with an overall PPV of 44.2%. We identified 668 AEs and no-harm incidents in 325 (54.2%) of the patients. The majority, 67.8%, were considered preventable. Over 95% of AEs resulted in temporary harm. The most common AEs were healthcare associated infection, falls and pressure ulcer. Forty percent of no-harm incidents were falls.

Conclusion No-harm incidents and AEs in home healthcare are common and mostly preventable. The TT can help healthcare organizations to measure, analyze and follow-up AEs and no-harm incidents that occur in home healthcare in order to improve patient safety.

8 Sep 2017, 15:40-16-40 (NA157) Poster

Stercoral colitis

Lee, Mei-Lin, Tu Chu-Li, Yu-Feng Tian
Chi-mei Hospital, Tainan, Taiwan

An 80 year-old woman presented with lower abdominal pain for days. Physical examination was unremarkable except abdominal distention, and lower abdominal tenderness. Computed tomography (CT) of abdomen revealed fecaloma in the rectum with inflammatory rectal wall and peri-rectal fat stranding, which was consistent with stercoral colitis. One episode of massive bloody stool developed during hospitalization, and the colonoscopy showed large linear circumferential ulcers with bloody clots and several red nipple signs found at rectal sigmoid colon. Her clinical condition was responded to conservative management with mesalazine enema, NPO, and parenteral nutrition.
Stercoral colitis is an inflammatory colitis that is caused by increased intraluminal pressure from fecaloma on the walls of the sigmoid colon, where the vascular supply was the most vulnerable. Because of prolonged localized pressure and compromised vessel supply, pressure ulcers may develop thereafter. Perforation of colon can occasionally occur due to the progression of pressure ulcers, and its associated mortality may be up to 35%.3 Early diagnosis of stercoral colitis is not easy because its manifestation may be non-specific. In this clinical condition, Abdominal CT can provide useful information for diagnosis, such as the presence of fecaloma, pericolonic stranding, perfusion defect, dense mucosa, colon wall thickening and proximal colon dilation.1 Moreover, if the presence of extraluminal gas or an abscess is detected by CT, it should indicate the diagnosis of colon perforation, and suggest surgical intervention for life-saving.

8 Sep 2017, 15:40-16-40 (NA159) Poster

Self-expandable metal stent(SEMS) Enhance The Patient Preoperative Life Quality

Tu Chu-Li
Chi-mei Hospital, Tainan, Taiwan

The self-expandable metal stent(SEMS) has been increasingly used for the management of malignant colorectal obstruction, not only as a palliative method but also as a preoperative treatment in surgical candidates.
In south of Taiwan, the self-expandable metal stent(SEMS) was no common to use in the colon obstruction because expensive equipment. In our case, a 78 old-year male has had hypertension and CKD, stage IV history. He suffered from abdominal fullness and constipation for 3 days. The abdomen CT scan showed rectal cancer. Colon ostomy can be arranging for relief the abdominal distension. But patient hesitate due to body image change, need to take care the colostomy and need to secondary operation to revision the ostomy. The he chose the ESMS for treatment. After two weeks, he received laparoscopic LAR successful.

8 Sep 2017, 15:40-16-40 (NA117) Poster

Falling in Hospitalized Patients Under the Influence of a Soporific – Analysis of Public Adverse Event Reports on the Web

Taiko TERASHIMA; Lecturer; Japanese Red Cross Hokkaido College of Nursing, Hokkaido, Kitami, Japan
Akiko Hiyama; Lecturer; Sapporo City University, Sapporo, Hokkaido, Japan
Junichi TANEMOTO; Assistant professor; Japanese Red Cross Hokkaido College of Nursing, Kitami, Hokkaido, Japan
Sadako Yoshimura; Emeritus professor; Faculty of Health Sciences, Hokkaido University, Sapporo, Hokkaido, Japan

[Objective] Falling is an adverse event caused by patient-related factors such as age and muscle weakness. The use of soporific agents in the presence of such factors has a significant impact, and the role of nurses in administering such medications cannot be ignored. We analyzed cases of falling after administration of soporific agents and determined management methods.

[Methods] In April 2017, we searched for reports on patients who fell while under the influence of any drug. Of a total of 497 search results, we selected the 238 that corresponded to patients who received soporific agents. We then classified the reports by time of day of the incident, soporific usage patterns, patient characteristics, event outcomes, and similarities in words extracted from event management strategies. We used descriptive statistics and the $\chi 2$-test for analysis.

[Results] Eighty percent of falls occurred at night, between 10 pm and 5 am, with a high proportion of patients waking during this time to use the restroom. Approximately half of the events occurred in patients over 80. Outcomes included bone fractures (58%). Approximately 60% of patients used soporific agents regularly. Only a few strategies involved assistance with sleeping such as warm baths for the feet.

[Conclusions] Although being unable to sleep is difficult for patients, managing sleep difficulties with soporifics confers a risk of falls. Therefore, it is important to provide sleep assistance that does not rely on soporifics by enlisting the cooperation of shift workers and families.

Key words; falling, soporific, strategy, inpatient, nurse

8 Sep 2017, 15:40-16:40 (NA033) Poster

Implementation of a patient education multimedia tool to enrich patient knowledge about their planned anesthesia care in advance of surgery

Kyan C. Safavi MD MBA, Yuri Chaves-Martins MD, Shu Lu MD, Emily Naoum MD, Gabrielle Paoletti MD, Katarina Ruscic MD PhD, Lisa Warren MD, Lisa Leffert MD
Massachusetts General Hospital, USA

Background
Patient participation in their own care reduces adverse events and improves satisfaction.1-6 Educating patients about their care plan is essential to effective participation.7-10 Patient education in anesthesia is critical given that patients with even high health literacy demonstrate a poor understanding of anesthesiologists' role and what to expect from anesthesia.11 Anesthesiologists are challenged by a lack of access to patients in advance of surgery. Time pressures on the day of surgery limit the ability to provide meaningful education.

Aim
Provide patients with a patient-centered multimedia tool that conveys accurate, relevant anesthetic information with the following criteria:
· Low cost to develop
· Free for patients
· Understandable at low health literacy levels
· Accessible at home

Results
Twelve residents and faculty volunteered to participate. Multimedia content was drafted for three common anesthesia scenarios. Content was reviewed by patient representatives to assure it was easy to understand and answered relevant questions. Residents acted in the videos, which were filmed by staff with the help of a hospital-hired filmographer and edited by faculty experts. Content was made available on the platform Vidscrip® and is offered to patients via: (1) email weblink, (2) surgical departmental websites, and (3) tablet in the preoperative suite.

Conclusion
We developed a multimedia tool with participation from staff and patient representatives for patients to have access to detailed, accurate information about their upcoming anesthesia care. Our approach may serve as a model for anesthesiologists seeking methods to provide meaningful education to patients in advance of their surgery.

8 Sep 2017, 15:40-16-40 (NA130) Poster

Working stress and coping strategies among intensive care nurses

Shu-Ching Lin, Shu-Ming Chen
Chi Mei Medical Center, Taiwan

The ICU has been a challenging, tense and busy working environment, in which nurses in the long-term exposure to such an environment, it is easy to Burn Out. To explore the correlation between work stress and coping strategies, and to find the predictors of stress perception and coping strategies, for improve the mental health of nurses and maintain the care quality. The analytical results reveal the working stress average 3.66, the top stressor in nursing is ‘inability to complete private work’; and coping strategies are most frequently used for ‘emotional coping’. Work-related stress is negatively correlated with certain dimensions of coping strategies. ‘Cardiac surgery intensive care ward’, ‘coping strategy – problem avoidance or shift’ and ‘coping strategy – problem solving’ are the predictors for work-related stress and account for 33% of variance.

8 Sep 2017, 15:40-16-40 (NA069) Poster

Characteristics of psychosocial support for supporters in disaster relief

Chikako Itagaki, Tadashi Ishii
Japanese Red Cross Medical Center, Japan

【Aim】We examine the characteristics of psychosocial support for supporters in disaster relief.
【Background】
The Japanese Red Cross Society has conducted psychosocial support for disaster victims.
We use the same method as WHO's psychological first aid.
It is well known that relievers are also under stress through support activities.
Especially administrative, firefighting and medical personnel who live in the affected areas, while being victims, they must become also a support side. They will get double stress in disaster situation.
Therefore, psycho-social support for supporters is also important.
【Method】
We examined support for supporters of the Japanese Red Cross Society at the various disaster support.
The target group was public health nurse, office staff and hospital staff who live in the disaster area, and medical relief team from outside of the affected areas.
We analyzed charts and questionnaires.
【Result】
The following features were seen in support for supporters.
1) Intervention of support was difficult.
2) They needed a long-term support.
3) There were various organizations to take over.
【Conclusion】
In support for supporters, it is important for us to understand and to act on its characteristics.
【Key Word】
psychosocial support
disaster
support for supporters

8 Sep 2017, 15:40-16-40 (NA076) Poster

Evaluation of inter-rater reliability and accuracy of the Fall Risk Behavior Assessment Tool (FRBA-Tool) for prediction of the risk of fall

Akiko Hiyama, Keiko Nakamura
Faculty of Nursing, Sapporo City University, Japan

Nurses are expected to assist patients in maintaining their activity, but often must also restrict activity to prevent fall. To ensure safety in hospitalized patients while maintaining activity, we developed the Fall Risk Behavior Assessment Tool (FRBA-Tool) and verified its predictive accuracy in a case-control study (Hiyama, 2016). To improve the utility of the tool, we conducted a survey of inter-rater reliability and a prospective investigation of verified prediction accuracy. The inter-rater reliability was examined by determining the kappa-statistic for evaluation of 86 patients by 43 nurses in 14 general wards at 3 hospitals. Assessment of the accuracy of prediction of fall risk was performed over 4 months in 11 general wards at 4 hospitals. Logistic regression after adjustment for age showed that all 18 items of FRBA-Tool were associated with fall. A receiver operating characteristic curve was used to evaluate the predictive performance of FRBA-Tool. Ethical approval for the study was granted by the institutional review board. Inter-rater reliability was high for the 18 items of FRBA-Tool (kappa=0.53-1.0). Based on logistic regression analysis, item scores were weighted and a total score cut-off point of 5 was obtained (AUC 0.81, 95%CI:0.71-0.90). Using this cut-off, FRBA-Tool had a sensitivity of 80.0% (95%CI: 0.63-0.98), specificity of 74.8% (95%CI: 0.71-0.78), positive predictive value of 3.17 (95%CI: 2.46-4.08), and negative predictive value of 0.27 (95%CI: 0.12-0.61). This study shows that FRBA-Tool has adequate reliability and accuracy for assessment of fall risk in hospitalized patients.

8 Sep 2017, 15:40-16-40 (NA128) Poster

Rapid communication with patient side to share the truth

Yukio Seki, Miho Kinoshita, Junichi Mizuno, Norie Tsuboi, Mitsuyo Ohno, Masaru Inoko, Yumiko Kose
Japanese Red Cross Nagoya Daini Hospital, Japan

Incident reporting system has been introduced in the Japanese Red Cross Nagoya Daini Hospital (812 beds) since 2002, and the number of reported incidents has increased to close to 5000 per year recently. For serious events whose influence levels are equal to or greater than 3b, case conference or RCA has been held regardless of presence of complaints. (around 45 case analyses per year) Our principle is to establish good communication with patients and his or her families after the events sharing the truth. To make the truth clear, a case conference is held with participants including hospital staffs involved in the event and doctors and paramedical staffs closely related to the event. When necessary, relevant specialists having no connection with us are invited to the conference from other hospitals. The result of the conference is reported to patient side without delay. Furthermore, serious events are reported to the head office of Japanese Red Cross, and comments on the events including hospital responsibility and suggestions for improvements in patient care are returned from the clinical safety committee. These comments are also shared with patient side and appropriate compensation is proposed if necessary in corporation with a lawyer. This approach to serious events resulted in reconciliation without any lawsuit for more than 5 years in our hospital.
Rapid action to share the truth behind clinical events is essential to avoid conflict in court and reach reconciliation with the least mental stress on both sides.

8 Sep 2017, 15:40-16-40 (NA074) Poster

Actual Use of Non-Technical Skills Related to Intravenous Drip Management by First-year Nurses in Japan

Saeko KINUGAWA, Noriko KUROSAWA
Division of Nursing faculty of Nursing, Tokyo Healthcare University, Japan

[Purpose] To investigate the usage situations of non-technical skills (NTS) by first-year nurses and to identify educational needs for improving skills.

[Methods] By anonymous, self-contained questionnaires by mail to he first-year nurses at 22 hospitals in February 2017, we asked to answer on 29 items on the usage situations of NTS regarding the intravenous drip management, consisting of 8 items on ""situation recognition"", 11 on ""decision-making"" and 10 on ""communication and teamwork"", on both ""frequency of implementation"" and ""degree of accomplishment"" on 4-point Likert scales.

[Results] We received 280 replies (collection rate of 48.9%) and adopted valid 274.
The average age of the participants is 23.8 years old (SD=4.1). 245 nurses (89.7%) experienced 30 times+ of IV management. 86 respondents (31.9%) experienced one incident/accident, and 92 respondents (34.1%) experienced more than once.
It is observed that ""situation recognition"" NTS were performed and the answer of ""somewhat confident"" was chosen by more than 60% of respondents with a high frequency. The ""clarifying the problem"" and ""decision-making"" NTS showed the lowest frequency of 40%, and 60% of respondents answered ""not confident"". The ""communication and teamwork"" NTS showed utilized with 70% of high implementation frequency, however, the answer, ""confident"" remained to be 50%.

[Discussion] The first-year nurses showed a tendency of a less frequency in implementing the NTS in ""decision-making"" on IV management, and also the tendency of not being confident in doing so. Therefore, it indicates the needs to (re)consider the future educational program to primarily improve the ""decision-making"" NTS.

8 Sep 2017, 15:40-16-40 (NA124) Poster

Introduction of TeamSTEPPS training for education of medical school 4th grade

Hiroshi OKUDERA, M.D.,Ph.D., Hisashi NAGASHIMA, M.D., Ph.D.
Masahiro Wakasugi, M.D., Ph.D. ,Yoko YAMAMOTO, R.N., M.Ms.
Etsuko NOGAMI, R.N., M.Ns.
Toyama University Hospital, Japan

TeamSTEPPS (Team Strategies and Tool to Enhance Performance and Patient Safety) is a teamwork system designed for health care professionals developed by Department of Defense (DoD) Patient Safety Program Agency for Healthcare Research and Quality (AHRQ). TeamSTEPPS has been accepted in one of effective training method in patient safety in Japan.
In Faculty of Medicine, University of Toyama, we designed introductory TeamSTEPPS training for medical school 4th grade student within education unit of patient safety and introduced experimentally, since 2015. For medical student, education module is designed based on the phase 1 of TeamSTEPPS, which is a necessary first step to implementing a teamwork initiative.
In Japan, clinical clarkship is started in the last semester of 4th grade, therefore the education unit of patient unit is scheduled just before clinical clarkship.
Since 2015, we performed the introductory one-day TeamSTTEPS training of for 221 medical student. Based on the response in questionnaire, most students show interest in medical safety and positive response in team training.
Details of the early experience in this study will be presented and further issues and measures for implementation of effective student education of medical safety will be discussed.

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Influence of our new nursing system called the Partnership Nursing System: PNS on medical safety and patients' satisfactions

Naomi Emori , Miho Murata , Yukie Takayama , Kumiko Asakawa , Kazue Suwa , Tomoko Hasegawa
University of Fukui Hospital, Japan

Background and objectives: The University of Fukui Hospital devised a new nursing delivery system called "the partnership nursing system: PNS" in 2009, and has systematically introduced it since then. The aim of the PNS is to enable nurses to provide both safe and high quality nursing. In the PNS, two nurses cooperate with and complement each other as effective, equal partners, taking advantage of each other's strengths to perform daily nursing cares and share achievements and responsibilities. The purpose of this study was to clarify impacts of PNS on medical safety and patients' satisfactions.
Method: The medical error incidents and near-miss documentations reported by the medical professionals including nurses and patient satisfactions were analyzed. Data were collected in 2012 and 2015.
Results: The total number of incidents was decreased about 22% from 2012 to 2015 (n=1106 in 2012 and n=868 in 2015). The incidents reported by the nurses decreased about 24% in 2015, compared to those in 2012 (n=962 in 2012 and 731 in 2015).
Patient satisfaction on "information transfer between paired nurses" was improved from 2012 to 2015.
Patient satisfaction on "Feeling of comfort with nurses on receiving medical treatments" was also slightly improved on 2015 compared to 2012. Other components of patient satisfactions were stayed on very high levels in both years.
Conclusions: The introduction of PNS might affects the nurses' medical error preventions and patients' satisfactions improvement.

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