

A Study on the Structure of Educational Content for Healthcare Quality and Safety

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1. Introduction

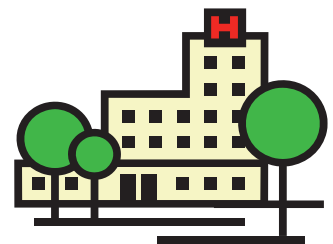
- In order to improve quality of healthcare . . .

Introduce Quality Management System (QMS)

- Education and Training for QMS

Acquire knowledge and master skills for

- establishing QMS
- healthcare safety



Not establish education system for QMS

1. Introduction

Purpose

Propose educational content for QMS and healthcare safety

Table.1 Educational contents for QMS -including healthcare safety- (partial)

Classification	First hierarchy	Second hierarchy	Detailed contents	Target people			
				staffs	managers	Committee	manager of QMS

Chapter 3
Process for developing table 1 (6 steps)

Chapter 4
Carry out education by utilizing table 1

2. Investigate the current situation and Consider the requirements

■ Current problems in hospitals

- (1) Education for QMS is not frequently carried out
- (2) Education is not continuous
- (3) Education for staffs except for newcomers is not frequently carried out

■ The requirements of the table of educational contents

- (a) Contents should cover necessary knowledge and skills for QMS
- (b) Contents can be utilized when any hospital plans education
- (c) Contents for all staffs need to be made clear

3 Process for developing educational contents

Step 1 Investigate the tasks of QMS and safety manager

Step 2 Consider classification and first hierarchy

Step 3 Refine the target people

Step 4 Consider the role of each target people

Step 5 Develop second hierarchy and detailed contents

Step 6 Consider the relations between contents and people

Classification	First hierarchy	Second hierarchy	Detailed contents	Target people			
				staffs	managers	Committee	manager of QMS
Each stage of PDCA cycle	Prevent the recurrence of the accidents	Reports about incidents	Purpose of reports	●	●	●	●
			Method to write reports	●	●	●	●
			Method to turn in reports	●	●	●	●
		Method of incidents analysis	RCA		●	●	●
			MedicalSAFER			●	●
Rotating PDCA cycle	Document Management System	Significance of document system	Significance of documentation	●	●	●	●
		Type of document	Significance of document system	●	●	●	●
			Regulations, manual	●	●	●	●

3. Process for developing educational contents

Classification	First hierarchy	Second hierarchy	Detailed contents	Target people			
				staffs	managers	Committee	manager of QMS
Each stage of PDCA cycle	Prevent the recurrence of the accidents	Reports about incidents	Purpose of reports	●	●	●	●
			Method to write reports	●	●	●	●
			Method to turn in reports	●	●	●	●
		Method of incidents analysis	RCA		●	●	●
			MedicalSAFER			●	●

Step 1 : Investigate the tasks of QMS and safety manager

Step 2 : Consider classification and first hierarchy based on investigated tasks in Step 1

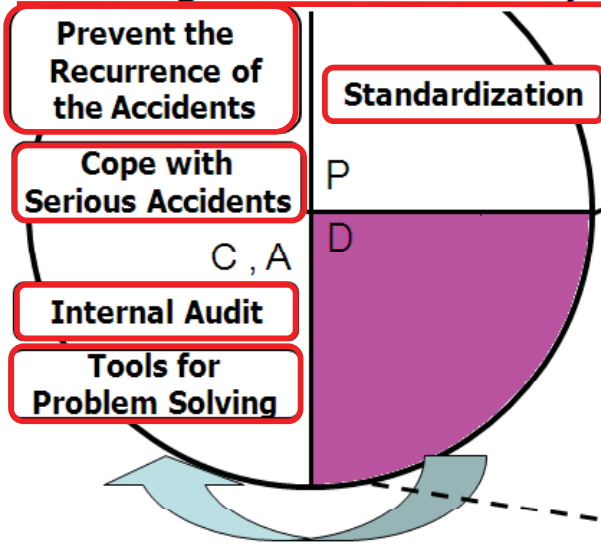
⇒ Classification : 4 types
 First hierarchy : 19 contents

Significance

Healthcare Quality and Safety

Fundamental Concept

Each Stage of PDCA Rotation Cycle



Offering Safety Healthcare Service

Working Method

Knowledge

Medical Devices and Medicines

Law of Medical Care

Information Management

Lawsuit and Insurance

Safety Action

Working Method for Preventing Incidents

Rotating PDCA Rotation Cycle

Document Management System

Committee

IT and Healthcare Safety

System for Healthcare Safety

System for Daily Management

Policy Management

Process for developing educational contents

Step 1 : Define the target people

Step 4 : Consider the role of each target people

The education which each staff should take is different

⇒ Divided the target people with regard to the role of QMS activities

Second hierarchy	Detailed contents	Target people			
		general staffs	managers of department	committee of QMS	manager of QMS
Reports about incidents	Purpose of reports	●	●	●	●
	Method to write reports	●	●	●	●
	Method to turn in reports	●	●	●	●
Method of incidents analysis	RCA		●	●	●
	MedicalSAFER			●	●

3. Process for developing educational contents

Step 5 : Develop second hierarchy and detailed contents

Classification	First hierarchy	Second hierarchy	Detailed contents	Target people			
				staffs	managers	Committee	manager of QMS
Each stage of PDCA cycle	Prevent recurrence of incidents	Reports about incidents Method of incidents analysis Method of countermeasures	Purpose of reports	●	●	●	●
			Method to write reports	●	●	●	●
			Method to turn in reports	●	●	●	●
			POAM	●	●	●	●
Rotation of PDCA cycle			RCA	●	●	●	●
			Medical SAFER	●	●	●	●
			Type of countermeasures	●	●	●	●
			Error Proofing	●	●	●	●

References

- The literature of QMS and healthcare safety
- The textbook for quality control and healthcare safety
- The result of analyzing the incidents

3. Process for developing educational contents

Step 6 : Consider the relations between contents and people referring to the role of each target people

First hierarchy	Second hierarchy	Detailed contents	Target people			
			staffs	managers	Committee	manager of QMS
Prevent the recurrence of the accidents	Reports about incidents	Purpose of reports	●	●	●	●
		Method to write reports	●	●	●	●
		Method to turn in reports	●	●	●	●
	Method of incidents analysis	POAM	●	●	●	●
		RCA	●	●	●	●
		Medical SAFER	●	●	●	●
	Method of countermeasures	Type of countermeasures	●	●	●	●
		Error Proofing	●	●	●	●
					
Document Management System	Significance of document system	Significance of documentation	●	●	●	●
		Significance of document system	●	●	●	●
	Type of document	Regulations, manual	●	●	●	●
	Concrete method of document management system	Making a document		●	●	●
		Approval of a document		●	●	●
.....				

Verification

Education plan in hospital A

Category	Educational content	Target Object	Date
Step1	1. KYT (Hazard Prediction Training)	Indispensable people are new comers and managers. Optional people are others.	18, 19, 25, 26 Jun. 2009 11, 12, 25, 26 Jun. 2010
	2. Reports about incidents		9, 10, 23, 24 Jul 2009 1, 3, 22, 23 Jul 2010
	3. Method of incidents analysis (POAM)		20, 21 Aug. 2009 26, 28 Aug. 2010
	4. Method of taking countermeasures (Error-Proof)		27, 28 Aug. 2009 16, 17 Sep. 2010
Step2	1. Standardization (Process Flow Chart)	People who received all education of Step1.	7, 8, Dec. 2010
	2. Method of incidents analysis (POAM)		17, 18 Dec. 2010
	3. Document Management System		13, 14 Jan. 2011

QMS manager in hospital A chose the contents

First hierarchy	Second hierarchy	Detailed contents	Target people			
			staffs	managers	Committee	manager of QMS
Prevent the recurrence of the accidents	Reports about incidents	Purpose of reports	●	●	●	●
		Method to write reports	●	●	●	●
		Method to turn in reports	●	●	●	●
	Method of incidents analysis	POAM	●	●	●	●
		RCA		●	●	●
		Medical SAFER			●	●
	Method of countermeasures	Type of countermeasures	●	●	●	●
		Error Proofing	●	●	●	●
					

4. Verification

4.2 Carry out education by utilizing table 1

Table.2 Education plan in hospital A

Category	Educational content	Target Object
Step1	1. KYT (Hazard Prediction Training)	Indispensable people are new comers and managers. Optional people are others.
	2. Reports about incidents	
	3. Method of incidents analysis (POAM)	
	4. Method of taking countermeasures (Error-Proof)	
Step2	1. Standardization (Process Flow Chart)	People who received all education of Step1.
	2. Method of incidents analysis (POAM)	
	3. Document Management System	

A way of education

- 1 hour per educational content
- Same content was carried out 4 times
- Exercise based on actual incident reports



4 Verification

4.2 Carry out education by utilizing table 1

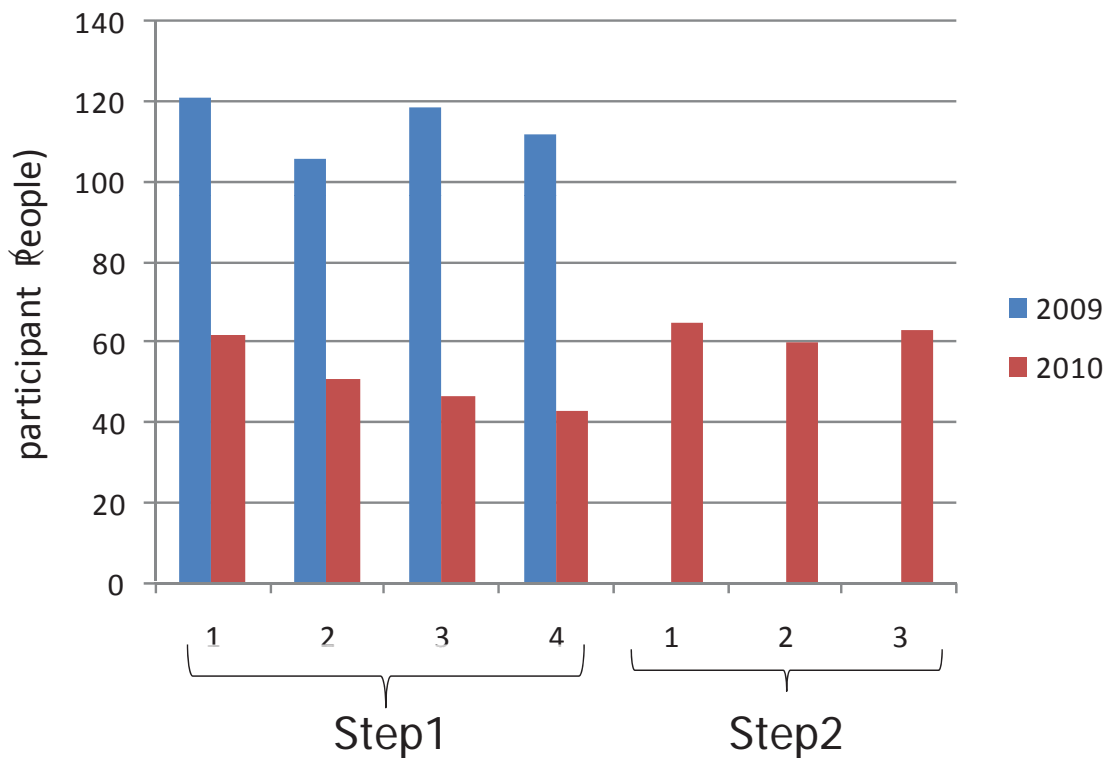


Fig. A The number of participant of education in hospital A

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4. Verification

4.2 Carry out education by utilizing table 1

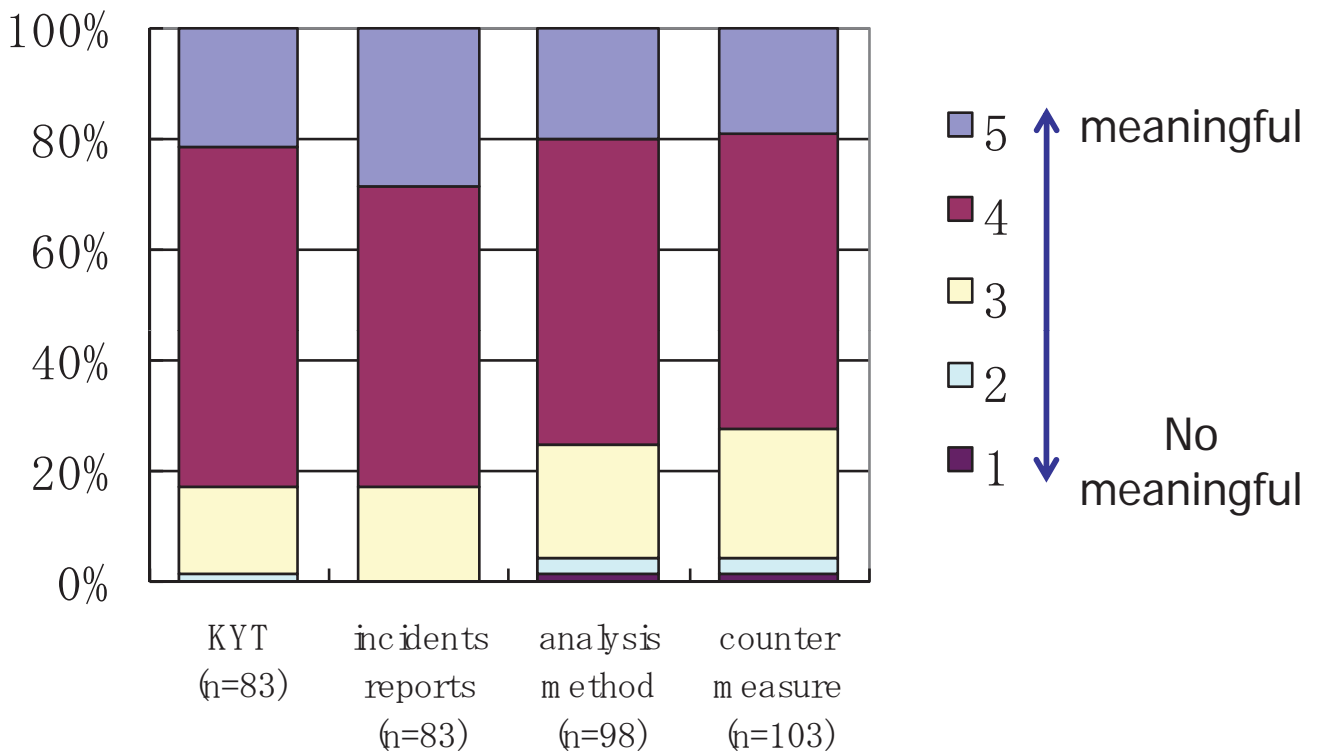


Fig. 2 The result of a questionnaire about a meaningful of each education of Step1

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Discussion Significance of this study

Table.1 Education contents for S including healthcare safety

Classification	First hierarchy	Second hierarchy	Detailed contents	Target people			
				staffs	managers	Committee	manager of QMS
Each stage of PDCA cycle	Prevent the recurrence of the accidents	Reports about incidents	Purpose of reports	●	●	●	●
			Method to write reports	●	●	●	●
		Method to handle incidents	Method to turn in reports	●	●	●	●
			RCA	●	●	●	●
Role of PDCA cycle	Prevent the recurrence of the accidents	Reports about incidents	Method to handle incidents	●	●	●	●
			MedicalSAFETY	●	●	●	●
Off-site safety education	Prevent the recurrence of the accidents	Reports about incidents	Method to handle incidents	●	●	●	●
			MedicalSAFETY	●	●	●	●

Proposed first hierarchy second hierarchy and detailed contents in order
 ⇒ possible to choose contents according to the state of S in each hospital
Fulfill requirement b

1

Conclusion and Future issues

Conclusion

We considered educational contents for S
 We carried out the education by utilizing the contents

Future issues

1. Verify the appropriateness of the relationships between educational contents and target people
2. Consider the method to evaluate the effect of education

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Thank you for your attention.

References

1. The Ministry of Health, Labor and Welfare in Japan 2005 Guidelines for a manager of healthcare safety <http://www.mhlw.go.jp>
2. Yoshinori Iijima *et al.* 2005 Quality Management System for Healthcare Service Guidelines for Small Japanese Standards Association
 - Committee for Education of Safety Manager 2005 Text for safety manager in hospital Japanese Standards Association
 - Shuhei Iida *et al.* 2011 Text for safety manager in hospital 4th edition Japanese Standards Association
 - Shuhei Iida *et al.* 2005 Dictionary of healthcare quality terms Japanese Standards Association