Joint Commission International Accreditation

FINAL ACCREDITATION SURVEY FINDINGS REPORT

Fujita Health University Hospital

Toyoake, Japan

International Health Care Organization (IHCO) Identification Number: 60006756

Survey Dates:	9 - 13 December 2024
Program:	Academic Medical Center Hospital
Survey Type:	Triennial
Surveyor Team:	Pauline Tan, MSc, MPA, RN, Nurse, Team Leader Dini Handayani, MD, MARS, FISQua, Administrator Shao Hua Ko, Physician Christine L. Sears, Physician Elijah J. Gilreath, RN, MSN, Nurse

OUTCOME:

Based on the findings of the Triennial Academic Medical Center Hospital survey of 9 December 2024 to 13 December 2024 and the Decision Rules of Joint Commission International (JCI), Fujita Health University Hospital has been granted the status of ACCREDITED.

Upon confirmation from the JCR Finance Department indicating that all survey related fees have been paid, you will receive the JCI Academic Medical Center Hospital certificates and, if necessary, your organization's entry on the JCI website will be updated. You also have access to The JCI Gold Seal of Approval™, the JCI Accreditation Gold Seal of Approval™ Guidelines, and the JCI Accreditation Publicity Guide under the "Resources" tab in JCI Direct Connect.

The Joint Commission International Academic Medical Center Hospital Standards are intended to promote continuous, systematic and organization-wide improvement in daily performance and in the outcomes of patient care. It is our expectation that all of the issues identified in the following survey report will have been satisfactorily resolved and full compliance with each identified standard will be demonstrated at the time of your next accreditation survey. Therefore, Fujita Health University Hospital is encouraged to immediately place organization-wide focus on the standards with measurable elements scored as "Not Met" and "Partially Met" and to implement the actions necessary to achieve full compliance.

Between surveys, Fujita Health University Hospital will be expected to demonstrate compliance with the most current edition of the JCI standards at the time, which includes the JCI accreditation policies and procedures published on the JCI website.

JCI will continue to monitor Fujita Health University Hospital for compliance with all of the JCI Academic Medical Center Hospital standards on an ongoing basis throughout the three-year accreditation cycle. The compliance monitoring activities may include but not be limited to document and record reviews, the review of data monitoring reports, leadership interviews and staff interviews. The monitoring activities may take place on-site or off-site. JCI also reserves the right to conduct an unannounced, onsite evaluation of standards compliance at its discretion.

REQUIRED FOLLOW-UP:

Some of the findings identified in this report suggest that if not attended to in a timely manner can evolve into a generalized threat to patient and/or staff health and safety and may over time result in a sentinel event. These health and safety risks would be counter to the improvement efforts your organization has accomplished to date, and counter to the spirit of continual improvement in quality and continual reduction of risk that are considered part of the accreditation process. This is of concern to us and we believe should be a priority concern for your organization. For this reason, a Strategic Improvement Plan (SIP) describing the sustainable measures that will be implemented to achieve full compliance is required for the following standard(s) and measurable element(s):

- FMS.8.1, ME #2
- MOI.4, ME #3
- MOI.13, ME #6

The SIP must be submitted to JCI within the next 60 days or by 17 Feb 2025 for review and acceptance. Details regarding access to the SIP system will be sent to you by way of a separate notification.

Survey Analysis for Evaluating Risk (SAFER)

Joint Commission International (JCI) has implemented the Survey Analysis for Evaluating Risk (SAFER) matrix, which is a comprehensive visual representation of survey findings. This will provide your healthcare organization with the information it needs to prioritize resources and focus strategic improvement plans in areas that are most in need of compliance activities and interventions.

SAFER will help your organization to:

- More easily identify Measurable Elements (ME) with higher risk
- Identify potential for widespread quality initiatives
- Better organize survey findings by level of potential patient, staff, and/or visitor impact

Each Measurable Element (ME) scored "Partially Met" or "Not Met" is placed on the SAFER matrix according to the likelihood the observation could harm a patient(s), staff and/or visitor(s) and the scope at which non-compliance was observed. As the risk level increases, the placement of the standard and ME moves from the bottom left corner (lowest risk level) to the upper right (highest risk level) of the matrix.

The definitions for the likelihood to harm a patient/staff/visitor and scope are as follows:

Likelihood to harm a patient/staff/visitor:

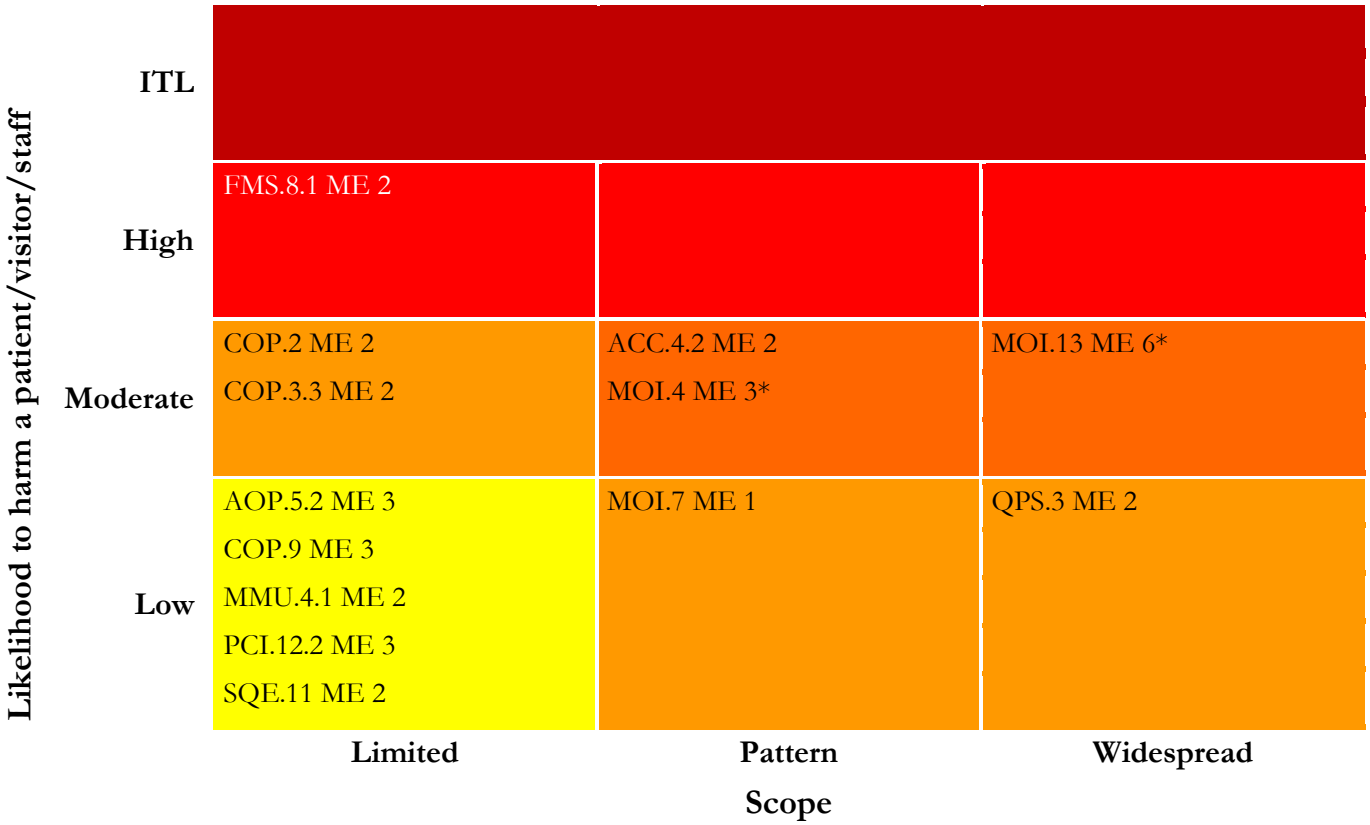
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

SAFER Matrix Placement	Strategic Improvement Plan (SIP) Required
High/Limited **High/Pattern** **High/Widespread**	• Not Met and Partially Met MEs will require a SIP
Moderate/Pattern **Moderate/Widespread**	• Only Not Met MEs will require a SIP
Moderate/Limited **Low/Pattern** **Low/Widespread**	• Not Met and Partially Met MEs will not require a SIP
Low/Limited	

SAFER Matrix
Program Name: AMC - Hospital



*Indicates Not Met

REPORT OF SURVEY FINDINGS:

Note: The Accreditation Committee may request follow-up for any or all of the standards after the accreditation decision.

Access to Care and Continuity of Care

ACC.4.2 **The complete discharge summary is prepared for all inpatients, and a copy of the discharge summary is contained in the patient's medical record.**

Measurable Element #2
The discharge summary contains at least a) through g) of the intent.
Partially Met

Likelihood to Harm: Moderate **Scope: Pattern**

Discharge summary was available in the electronic medical record for physician review; however, in only one of three closed medical records reviewed, the medications which the patient was to take at home after discharge were included in the discharge summary in accordance with item (e) in the intent.

This was a repeat finding from the last survey.

Assessment of Patients

AOP.5.2 **A qualified individual is responsible for the oversight and supervision of the point-of-care testing program.**

Measurable Element #3
The POCT program includes a defined process for reporting abnormal test results, including reporting critical results.
Partially Met

Likelihood to Harm: Low **Scope: Limited**

Policy FHUH7-AOP.5.2 indicated that reporting Point-of-Care-Testing (POCT) critical value should follow the policy of IPSG.2.1 (FHUH7-IPSG.2.1); however, the critical values and the process for reporting POCT critical results were not described or defined in IPSG.2.1 policy document.

Care of Patients

COP.2 **There is a process to integrate and to coordinate the care provided to each patient, and it includes a uniform process for prescribing patient orders.**

Measurable Element #2
The hospital develops and implements a uniform process for prescribing written/documented patient orders that includes identifying orders that may be received verbally, via telephone, and via text.
Partially Met

Likelihood to Harm: Moderate **Scope: Limited**

The hospital policy required mechanical ventilator setting in Intensive Care Unit should be stated as a standing order in the medical record by physicians; however, in the Neurosurgical Intensive Care Unit, setting of the mechanical ventilator was ordered verbally by physician. Meanwhile, the nurses did not follow the process for receiving and recording verbal order as per policy FHUH7-IPSG.2 to record the name of supervising physician and to obtain the confirmation.

COP.3.3 **Resuscitation services are available throughout the hospital.**

Measurable Element #2

Medical equipment for resuscitation and medications for basic and advanced life support are standardized and available for use based on the needs of the population served.

Partially Met

Likelihood to Harm: Moderate **Scope: Limited**

The Pediatric Outpatient Department provided adult and pediatric resuscitation medical equipment in the resuscitation cart; however, the pediatric Ambu bag was found to be kept separate from the rest of the resuscitation equipment.

COP.9 **Transplant programs that perform living donor transplantation adhere to local and regional laws and regulations and protect the rights of prospective or actual living donors.**

Measurable Element #3

An individual with knowledge of living organ donation, transplantation, medical ethics, and informed consent is identified and appointed as an advocate for the living donor.

Partially Met

Likelihood to Harm: Low **Scope: Limited**

This hospital assigned a clinical psychologist as the advocate for living donors and followed the domestic guideline on living donor advocate; however, in the policy document (FHUH7-COP.9.1/9.2) on transplantation program using living donor, no content regarding advocate for living donor was mentioned.

Facility Management and Safety

FMS.8.1 **The fire safety program includes the early detection, suppression, and containment of fire and smoke.**

Measurable Element #2

The fire safety program includes equipment/systems for the suppression of fire.

Partially Met

Likelihood to Harm: High **Scope: Limited**

The In-Vitro Fertilization Department (IVF) did not have fire suppression equipment. The nearest suppression equipment was a fire hose located outside the department about 10 meters from the unit along a common corridor. This posed risk to safe evacuation of occupants should a fire occur in the department and block the only entrance/exit door of the unit.

Medication Management and Use

MMU.4.1 The hospital identifies those qualified individuals permitted to prescribe or to order medications.

Measurable Element #2

The hospital establishes and implements a process to place limits, when appropriate, on the prescribing or ordering practices of individuals.

Partially Met

Likelihood to Harm: Low **Scope: Limited**

For clinical trial medication, the electronic medical record system of this hospital limited the trial medication prescription according to the participant list, not the privilege of physicians. Physicians who were not privileged as investigators or sub-investigators of the clinical trial could still access the system and prescribe the trial medication to the participants.

Management of Information

MOI.4 The hospital uses standardized diagnosis and procedure codes and ensures the uniform use of approved symbols and abbreviations across the hospital.

Measurable Element #3

If the hospital allows abbreviations, the hospital implements the uniform use of approved abbreviations, and each abbreviation has only one meaning.

Not Met

Likelihood to Harm: Moderate **Scope: Pattern**

The hospital developed and promulgated a list of approved abbreviations; however, the following were observed in the document review:

1. Policy FHUH7-IPSG 3/3.2 "Safe management of high-alert medications, look alike-sound alike medications, high concentrated electrolytes" used the abbreviation MMU; however, this was not on the approved abbreviations list.
2. Policy FHUH7-IPSG 4/4.1 "Ensuring correct site, correct procedure, and correct patient surgery" used the abbreviation ID and defined it as identification in the abbreviations portion of the policy; however, this was not on the approved abbreviations list.
3. Policy FHUH7-ACC 2/2.3 "Managing the flow of patients throughout the hospital" included the abbreviation GCU and defined it as the Growing Care Unit in the abbreviations portion of the policy; however, this was not on the approved abbreviations list.
4. Policy FHUH7-ASC 3/3.2 "Administration of procedural sedation" included the abbreviations ACLS, ICLS AHA, MPADSS, and defined them in the abbreviations portion of the policy; however, these were not on the approved abbreviations list.
5. ASA was defined as American Society of Anesthesiologists in ASC 3/3.2 policy however as Acetylsalicylic Acid on the approved abbreviation list; and RRa was defined as acoustic respiratory rate in the ASC 3/3.2 policy; however, it was right renal artery in the approved abbreviation list.
6. A total of 155 approved abbreviations were also included in the unapproved abbreviations. Examples included, however were not limited to, the following:
   - AA approved for Aplastic Anemia; unapproved for Aortic Valve Atresia
   - ARF approved for Acute Renal Failure; unapproved for Acute Respiratory Failure
   - ASA approved for Acetyl Salicylic Acid; unapproved for American Society of Anesthesiologist
   - BG approved for Biguanide; unapproved for Basal Ganglia
   - CRT approved for Chemotherapy; unapproved for Cardiac Resynchronization Therapy

- CSI approved for Cranio Spinal Irradiation; unapproved for Chemical Shift Imaging
- DPT approved for Diphtheria Pertussis Tetanus; unapproved for Dual-Port Thymectomy
- E approved for Early; unapproved for Early Systolic Wave, E-Wave Velocity, Early Diastolic Filling Velocity
- ET approved for Ejection Time; unapproved for Embryo Transfer
- FD approved for Fibrous Dysplasia; unapproved for Full Denture, First Desire of Voiding
- GBM approved for Glioblastoma; unapproved for Glioblastoma Multiforme
- GS approved for Gallstone, unapproved for Gestational Sac
- HL approved for Hyperlipidemia, unapproved for Hodgkins Lymphoma
- ICH approved for Intracerebral Hemorrhage, unapproved for Intracerebral Hematoma
- L approved for Lumbar; unapproved for Long-Acting Insulin
- MTD approved for Minimal Target Dose; unapproved for Muscle Tension Dysphonia
- NTG approved for Nitroglycerin; unapproved for Normal Tension Glaucoma
- PO approved for Per OS; unapproved for Prosthetist & Orthotist
- RMS approved for Rhabdomyosarcoma; unapproved for Remote Monitoring System
- SCA approved for Subclavian Artery; unapproved for Spino Cerebellar Ataxia
- TA approved for Tricuspid Atresia; unapproved for Tibialis Anterior muscle
- TAI approved for Trans arterial Infusion Therapy; unapproved for Transcatheter Arterial Infusion
- VD approved for Ventricular Drainage; unapproved for Vascular Dementia
- WT1 approved for Willms Tumor 1; unapproved for Automated Immunochromatography Staining Program

MOI.7 Documents, including policies, procedures, and programs, are managed in a consistent and uniform manner.

Measurable Element #1

There is a written guidance document that defines the requirements for developing and maintaining policies, procedures, and programs, including at least items a) through h) in the intent.

Partially Met

Likelihood to Harm: Low **Scope: Pattern**

The following were observed:

1. The hospital policy "Consistent and Uniform management of Documents" FHUH-MOI 7/7.1 defined the requirements for developing and maintaining policies, procedures, and programs, including items a) through h) in the intent, other than item d) of the intent, "How changes in a document can be identified."
2. The hospital indicated that policies were reviewed annually, and if any changes were made, they were included in the current policy on the eValue documentation system; however, the actual changes were not identified and evident in the policies.
3. The hospital tracked changes in the eValue system; however, those changes were not available for the staff.

MOI.13 **The hospital develops, maintains, and tests a program for response to planned and unplanned downtime of data systems.**

Measurable Element #6

Staff are trained in the strategies and tactics used for planned and unplanned downtime of data systems.

Not Met

Likelihood to Harm: Moderate **Scope: Widespread**

The hospital regularly conducted training for both planned and unplanned downtime; however, the following were observed:

1. In 2023, only 0.3% of staff relevant to the training participated in planned downtime, while 0.7% were trained for unplanned downtime.
2. In 2024, 0.9% of relevant staff participated in planned downtime, and 0.6% received training for unplanned downtime.

Prevention and Control of Infections

PCI.12.2 **The hospital develops, implements, and evaluates an emergency preparedness program to respond to the presentation of global communicable diseases.**

Measurable Element #3

The hospital evaluates the entire program at least annually and, when applicable, involves local, regional, and/or national authorities.

Partially Met

Likelihood to Harm: Low **Scope: Limited**

The hospital had developed and implemented an emerging infectious diseases preparedness program and was in the process of evaluating the entire program in collaboration with other disaster medicine response programs.

Quality Improvement and Patient Safety

QPS.3 **Hospital leadership builds a culture and environment that supports implementation of evidence-based care through the use of current scientific knowledge and information to support patient care, health professional education, clinical research, and management.**

Measurable Element #2

Current scientific knowledge and information supports patient care.

Partially Met

Likelihood to Harm: Low **Scope: Widespread**

Current scientific knowledge and information were used to support patient care; however, numerous policies were found with outdated, not dated, or lacking in references. These included, however are not limited to:

1. Improving Accuracy of Patient Identification FHUH7-IPSG.1
2. Improving the Effectiveness of Verbal and / or Telephone Communication HUH7-IPSG.2
3. Reducing the Risk of Patient Harm from Falls FHUH7-IPSG.6/6.1
4. Risk Management Program FHUH7-QPS.10
5. Ensuring Effective Communication Throughout the Hospital
6. Framework for FUJITA HEALTH UNIVERSITY HOSPITAL Ethical Management HUH7-GLD.3.2, HUH7-GLD.12-12.2
7. Fire Safety Program FHUH7-FMS.8-8.4
8. Laboratory Safety Program FHUH7-AOP.5.3/ 5.3.1
9. Qualification of the responsible of Point-of-care-testing Program FHUH7-AOP.5.2
10. Identifying and Managing Sentinel Events, Adverse, No Harm and Near Misses Events FHUH7-QPS 7/7.1
11. Safe management of high-alert medications, look alike-sound alike medications, high concentrated electrolytes policy FHUH7-IPSG 3/3.2
12. Ensuring correct site, Correct procedure, and correct patient surgery policy IPSG 4/4.1: FHUH7 IPSG 4/4.1
13. Administration of procedural sedation policy FHUH7 ASC 3/3.2
14. Physiological status monitoring during and after surgery/anesthesia policy FHUH7 ASC 6/6.1

Staff Qualifications and Education

SQE.11 **The hospital uses an ongoing standardized process to evaluate the quality and safety of the patient care provided by each medical staff member.**

Measurable Element #2

The ongoing professional practice evaluation process identifies areas of achievement and potential improvement related to the behaviors, professional growth, and clinical results of the medical staff member, and the results are reviewed with objective and evidence-based information as available. These results are compared to other department/service medical staff members.

Partially Met

Likelihood to Harm: Low **Scope: Limited**

The ongoing professional practice evaluation process identified areas of achievement and potential improvement related to behaviors, professional growth, and clinical results of medical staff member; however, on comparing with other department/service medical staff members, nine of twelve (75% compliance) revealed measurement indicators related to the professional performance of individual physician. Otherwise, they were using only volume-based measurement for unit-specific professional practice evaluation.