Quality Assurance and Risk Management in Gastroenterology

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Quality and Risk in Gastroenterology

“Medicine used to be simple, ineffective and relatively safe. Now it is complex, effective and potentially dangerous” (Chantler) [1]. Gastroenterology includes the consultation and endoscopy sections that could not be separated, and together expose the patients to clinical errors and procedure complications, and the physician to law suits. In USA gastroenterology takes the 6th place in the number of claims, and the 16th place in the amount of money paid to the plaintiff [2]. In a recent study from Japan, a significant increase in the number of claims for inappropriate treatments was found between the periods of 1990-1999 and 2000-2009 [3]. No significant change was demonstrated for inappropriate treatments was found between the periods of 1990-1999 and 2000-2009 [3]. No significant change was demonstrated for inappropriate treatments was found between the periods of 1990-1999 and 2000-2009 [3].

Summary and Conclusion

Accountability of gastroenterology units in the community and hospital is depended on quality and risk management. Daily, routine work, endoscopy performance and patients’ management should be performed according to guidelines and clinical protocols, and followed persistently with quality indicators.

References


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### Table 1: Quality indicators developed for assessing the Integrated Gastroenterology Service.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Denominator</th>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone densitometry for patients with IBD</td>
<td>Patients &gt;20 years old with Crohn's disease or ulcerative colitis</td>
<td>Of those in the denominator, patients who underwent bone densitometry within the last 5 years</td>
</tr>
<tr>
<td>Preventive medications for high risk patients on aspirin / NSAIDs</td>
<td>High-risk patients (&gt;70 years old, underlying comorbidity or concomitant medications) on chronic aspirin / NSAIDs therapy</td>
<td>Of those in the denominator, patients who were prescribed proton pump inhibitors</td>
</tr>
<tr>
<td>Colonoscopy following positive FOBT</td>
<td>Patients with positive FOBT</td>
<td>Of those in the denominator, patients who underwent colonoscopy within 6 months</td>
</tr>
<tr>
<td>EGD in Barrett's esophagus</td>
<td>Patients with a diagnosis of Barrett's esophagus</td>
<td>Of those in the denominator, patients who underwent EGD within the last 3 years</td>
</tr>
<tr>
<td>Poor preparation for colonoscopy</td>
<td>Patients who underwent colonoscopy</td>
<td>Of those in the denominator, patients for whom the interpretation of the gastroenterologist was &quot;medium preparation&quot;, &quot;poor preparation&quot;, &quot;no preparation&quot; or &quot;unable to perform colonoscopy&quot;,</td>
</tr>
<tr>
<td>EGD for GERD patients over 45 years</td>
<td>Patients over 45 years old with a diagnosis of GERD</td>
<td>Of those in the denominator, patients who underwent EGD within the last 3 years</td>
</tr>
<tr>
<td>Unplanned EGD / surgery following EGD</td>
<td>Patients who underwent EGD</td>
<td>Of those in the denominator, patients who underwent unplanned repeat EGD or surgery within 72 hours</td>
</tr>
<tr>
<td>Repeated colonoscopy for patients with CRC</td>
<td>Patients with CRC in colonoscopy</td>
<td>Of those in the denominator, patients who underwent follow-up colonoscopy within 12-18 months</td>
</tr>
</tbody>
</table>

IBD = Inflammatory Bowel Disease; NSAIDs = Non-steroidal Anti-inflammatory Drugs; FOBT = Fecal Occult Blood Test; EGD = Esophago-Gastro-Duodenoscopy; CRC = Colorectal Cancer