ISQua13-1236

PROGRESS IN JAPANESE NATIONWIDE MEDICAL ADVERSE EVENT REPORTING SYSTEM IN 2012

Shin USHIRO, MD, PhD

Director,
Japan Council for Quality Health Care (JCQHC)

♦ Division of Adverse Event Prevention
♦ Division of Japan Obstetric Compensation System Operation
About JCQHC

featured by the wide variety of projects
<table>
<thead>
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<th>Project Description</th>
<th>URL</th>
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<tr>
<td>Hospital Accreditation</td>
<td><a href="http://www.jcqhc.or.jp/">http://www.jcqhc.or.jp/</a> with English page</td>
</tr>
<tr>
<td>Patient Safety Promotion Group of Among Accredited Hospitals</td>
<td><a href="https://www.psp.jcqhc.or.jp/modules/top/">https://www.psp.jcqhc.or.jp/modules/top/</a> written in Japanese</td>
</tr>
<tr>
<td>EBM medical information division</td>
<td><a href="http://minds.jcqhc.or.jp/">http://minds.jcqhc.or.jp/</a> written in Japanese</td>
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Nationwide Reporting System to Collect Medical Near-miss/Adverse Event Information from Hospitals and Clinics

Japan Council for Quality Health Care (JCQHC)
Overview of the reporting system

**Aim**

Patient safety and prevention of medical accident (No blame)

**Outline**

Background
Preventive measure

**Adverse event database**

**Training program (RCA)**

**Stirring committee**

**Expert Committee**

**Secretariat**

**JCQHC**

**Accident**

Hospitals (Mandatory)
- University Hospitals
- National Hospitals etc.

Hospitals (Voluntary)

**Near-miss (Incident)**

Hospitals (Voluntary)

- On-site visit (Voluntary survey)

**Web reporting**

① Cord-choice

② Description

**Aim**

Outline

**Background**

**Preventive measure**

**Annual/Quarterly report**

**Medical safety information**

**On-site visit**

**Expert Committee**

**Stirring committee**

**Secretariat**

**General public**

Health care professionals/
facilities

**Government**
Medical institutions subject to reporting under the government’s ordinance

A) National centers for specific diseases and national sanatoriums for Hansen’s disease operated by the National Hospital Organization (Government Agency)

B) University Hospitals governed by the School Education Law (not including their branch hospitals)

C) Advanced treatment facilities*

*Most hospitals categorized in C) is university hospitals.
Mandatory/Voluntary Institutions

No. Hospitals-Mandatory 273
No. Hospitals-Voluntary 637
Total 910

BASIC STATISTICS
Note 1: No. of Hospitals in Japan ~8,650
Note 2: No. of Hospital Beds in Japan
   Mandatory reporting hosp. ~140,700 beds
   All hosp. ~1,600,000 beds

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### Year-to-year change in the number of reporting

**Accident**

The bar chart illustrates the year-to-year change in the number of accident reports and institutions from 2005 to 2013. The data is categorized into mandatory and voluntary reports.

<table>
<thead>
<tr>
<th>Status/Year</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013 Jan-Jun</th>
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<tbody>
<tr>
<td>Mandatory</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. Report</td>
<td>1114</td>
<td>1296</td>
<td>1266</td>
<td>1440</td>
<td>1895</td>
<td>2182</td>
<td>2483</td>
<td>2535</td>
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<td>273</td>
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<td>273</td>
<td>272</td>
<td>273</td>
<td>273</td>
<td>273</td>
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<tr>
<td>Voluntary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. Report</td>
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<td>155</td>
<td>179</td>
<td>123</td>
<td>169</td>
<td>521</td>
<td>316</td>
<td>347</td>
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<tr>
<td>No. Institutions</td>
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<td>300</td>
<td>285</td>
<td>272</td>
<td>427</td>
<td>578</td>
<td>609</td>
<td>653</td>
<td>680</td>
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</table>
Quarterly/Annual report

Medical safety information

Japan Council for Quality Health Care (JCQHHC)
Types of Reports

- Quarterly report No. 1-34
- Annual report 2005-2012
- Reports are Released at Press conference
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Background and outline of the project
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   [9] Administration of Allergic Drug to Patient with Previous Known Allergy: History (Medical Safety Information No. 33)

Analysis by Individual Topics

Notification of recurrent cases previously shown in alerts or individual topics
**Summary of Adverse Event**

"Nursing care" and "Treatment and procedure" which include "fall" and "surgery" respectively are the most common cases.

*(Annual report 2010)*

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Individual themes analyzed

- Retained surgical materials and metal devices
  - Adverse events related to Pathological Test
  - Adverse events related to Therapeutic Diet Supply
  - Adverse events related to hand-over failure between or within medical institution
  - Wrong intake of drug package sheet
  - Adverse events related to management of vaccine expiration date
  - Wrong prescription of contraindicated drug to patient with diabetes mellitus under hemodialysis treatment
  - Wrong dispensing of powdery drug
  - Tube misconnection in relation to endo-tracheal tube
  - Thermal burn caused by light source of endoscopy
  - Wrong ordering of dosage at admission to Intensive Care Unit (ICU)
  - Failure of transmission of report on diagnostic imaging
  - Adverse events related to display of drug names and transfusion names in electronic ordering system
Retained foreign objects during surgery

(cited from a topic of “Retained surgical material and metal devices”)

<table>
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<tr>
<th>Year</th>
<th>2003 (Oct-Dec)</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008 (Jan-Sep)</th>
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<tr>
<td>Gauze</td>
<td>3</td>
<td>9</td>
<td>26</td>
<td>15</td>
<td>15</td>
<td>68</td>
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<tr>
<td>Cotton ball, etc.</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>10</td>
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<tr>
<td>Needle for suture</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>12</td>
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<tr>
<td>Forceps</td>
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<td>1</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>7</td>
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<tr>
<td>Scarpel blades</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Tubes</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
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<tr>
<td>Others</td>
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<td>7</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>22</strong></td>
<td><strong>40</strong></td>
<td><strong>28</strong></td>
<td><strong>24</strong></td>
<td><strong>124</strong></td>
</tr>
</tbody>
</table>
Retained surgical material (Gauze)

Anterior view: Thread woven in a gauze

Lateral view: Thread woven in a gauze

Ref: 2007 Annual Report
Key words for search: “Insulin”

Two reports are matched.

Choose “adverse event” or “near-miss event”

Choose “Year/Month of occurrence”

Choose “classification of events”

Browse
Title:
Reception error of patient’s ECG waveform in central monitoring system

Summary of the case:
Five cases of conducting treatment and procedures to patients, in which the electrocardiogram (ECG) monitor displayed by another patient as one telemetry transmitter sent ECG waveform to multiple locations, have been reported.

Key statement:
All the ward in question, the electrocardiogram of the patients in the ward were monitored using multiple monitors in central monitoring system. The nurse input the incorrect channel number of telemetry transmitter when setting up the central monitor to display the electrocardiogram of patient A. The input number was that for patient B, so the electrocardiogram of patient B was displayed instead of that of patient A. The electrocardiogram displayed as patient A although actually that of patient B showing ventricular fibrillation, and the patient was erroneously treated.

Illustration to help the understanding the key statement:

Preventive measures taken in the institution in which the event happened:
- Confirm if the electrocardiogram channel number being received matches the channel number of telemetry transmitter attached to the patients.
- Establish the setting rule of central monitors.
Reception error of patient’s ECG waveform in central monitoring system

Illustration to describe Case 1

Patient “A” was diagnosed and immediately treated for ventricular tachycardia.

Channel was set wrong for ECG of Patient “B”.

Patient “B” was left untreated for a while.
Release of Medical Safety Information

JCQHC

5,306 registered medical institutions (60% of Hospitals)

Website Healthcare professionals

FAX Patients General public

Japan Council for Quality Health Care (JCQHC)
App for Global Patient Safety Alerts

Global Patient Safety Alerts is an innovative information-sharing resource to help you prevent and mitigate patient safety incidents in your organization and help others succeed.
The nation wide adverse event reporting system is now widely welcomed and utilized in Japanese medical society and related societies.

The achievement of the reporting system is due to the growing patient safety culture and understanding and cooperation by medical institutions, government, manufacturers and other bodies related to medicine.