About JCQHC

featured by the wide variety of projects

Projects carried in JCQHC for quality and safety improvement

Hospital Accreditation

Patient Safety Promotion Group of Among Accredited Hospitals

EBM medical information division

Nationwide Reporting System on Medical Adverse Events from Medical Institution
(https://www.med-safe.jp/ with English page)

Nationwide Reporting System on Near-miss Event from Community Pharmacy
(http://www.yakkyoku-hiyari.jcqhc.or.jp/contents/outline/index.html with English page)

The Japan Obstetric Compensation System for Cerebral Palsy
(http://www.sanka-hp.jcqhc.or.jp/ written in Japanese)

Nationwide Reporting System to Collect Medical Near-miss/Adverse Event Information from Hospitals and Clinics

Overview of the reporting system

Medical institutions subject to reporting under the government’s ordinance

A) National hospitals and 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
  
**Publications**

- **Quarterly/Annual report**
- **Medical safety information**

**Types of Reports**

- **Quarterly** report No. 1-34
- **Annual** report 2005-2012
- Reports are Released at Press conference

**Table of Contents**

- Background and outline of the project
- Tabulation of code-reporting by near-miss and adverse event

**Table of Contents (cont’d)**

- 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)

**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 vaccinne expiration date
- Wrong prescribing 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**

(Adapted from a topic of "Retained surgical material and metal devices")

<table>
<thead>
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<th>Year/Period</th>
<th>2003 (Oct-Dec)</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</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>
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<td>0</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>10</td>
</tr>
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<td>Needle for suture</td>
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<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>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>
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<td>Others</td>
<td>3</td>
<td>7</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>22</td>
<td>40</td>
<td>28</td>
<td>24</td>
<td>124</td>
</tr>
</tbody>
</table>

**Retained surgical material (Gauze)**

Ref: 2007 Annual Report

**Web-based search for reported cases**

Key words for search: "Insulin"

Two reports are matched.

**Medical Safety Information**

Summary of the case

Key statement

Illustration to help understanding the key statement

Preventive measures taken in the institution in which the event happened
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.

Japan Council for Quality Health Care (JCQHC)

Release of Medical Safety Information

JHQHC

5,306 registered medical institutions (80% of Hospitals)

FAX

Website

Healthcare professionals

Patients

General public

Japan Council for Quality Health Care (JCQHC)

App for Global Patient Safety Alerts

Sharing for Learning

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.

App

Country

Organization

Team

Environment

England and Wales

Hong Kong

Japan

United Kingdom

United States of America

Errors Involving Drug-Related Clinical Monitoring

This article discusses the importance of clinical monitoring

JCQHC

Conclusion

- 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.

See you in KYO for ISQua annual meeting in 2016!

Thank you for your attention!