Project to Collect Medical Near-miss/ Adverse Event Information 2021 Annual Report

公益財団法人　日本医療機能評価機構
Japan Council for Quality Health Care
Division of Adverse Event Prevention

The current status of the project can be browsed at:
Website: https://www.med-safe.jp/
English page: https://www.med-safe.jp/contents/english/index.html

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*This Annual Report has been prepared as part of the Project to Collect Medical Near-miss/Adverse Event Information (project subsidized by the Ministry of Health, Labour and Welfare), based on information about medical adverse events gathered by the project and informed by the opinions of members of the Comprehensive Evaluation Panel, for the purpose of preventing the occurrence and recurrence of medical adverse events. Please refer to the project website for details about the purpose of the project. https://www.med-safe.jp/

*While the JQ takes all possible steps to ensure that the information carried in this report is accurate at the time of compilation, it does not guarantee that the content will remain accurate in the future.

*In preparing this information, the JQ intends neither to restrict the discretion of medical professionals, nor to impose any obligations or responsibilities on them.

Greeting

Hirobumi Kawakita
President
Japan Council for Quality Health Care

The foundational principles of the Japan Council for Quality Health Care are to carry out projects relating to improving the quality and safety of health care and ensuring reliable medical care from a neutral, scientific perspective, and to contribute to improving the health and welfare of the populace. We believe that an evaluation body's value lies in, among others, building relationships of trust and working in partnership with patients and their family members, medical providers, and all other stakeholders; maintaining fairness, without bias in any direction; and ensuring transparency and fulfilling the duty of accountability to society. These principles and values form the foundations of all the projects that we operate: Hospital Accreditation, Patient Safety Promotion, the Project to Collect Medical Near-miss/Adverse Event Information, the Project to Collect and Analyze Pharmaceutical Near-Miss Event Information, the Medical Information Network Distribution Service (MINDS), and the Japan Obstetric Compensation System for Cerebral Palsy.

In FY2004, the Division of Adverse Event Prevention began implementing the Project to Collect Medical Near-miss/Adverse Event Information, which gathers information about medical adverse events and medical near-miss events, with the objective of promoting safety in medical care. The information gathered concerning medical adverse events is compiled into quarterly reports, in which the total figures for the events and an analysis thereof are also published. These regular quarterly reports and annual reports are made available to a wide range of individuals and organizations in society, including medical professionals, the public, and government bodies. In addition, Medical Safety Information is sent out by fax to medical institutions about once a month. I would like to express my deepest gratitude to the medical institutions that cooperate with our project by reporting medical near-miss and adverse event information, and also to all other stakeholders.

We are now publishing the 2021 Annual Report, which is based on the content of previously published quarterly reports. This report carries a large volume of information that can help to promote medical safety, including annual totals for medical near-miss and adverse event information, overviews of analysis themes and recurrent and similar event analyses, and an overview of workshops held. Accordingly, we hope that this Annual Report will be of use to those working in clinical practice, as well as helping the public to gain a deeper understanding of Japan's medical safety initiatives as they stand at present.

Having received considerable feedback on the reports we have published to date, including media coverage and inquiries about medical adverse event information figures and the details thereof, we are keenly aware that public concern about the promotion of medical safety and the prevention of medical adverse events is high. We will strive to further enhance the content of our quarterly reports, annual reports, and Medical Safety Information, so that we continue to provide everyone with useful information.

In addition, we at the JQ intend to do our utmost to improve the quality of medical care and ensure public confidence in it through such projects as Hospital Accreditation, thereby raising the standard of Japanese medical care. We would therefore be most grateful for your continued understanding and cooperation.

Foreword

Shin Ushiro
Director
Japan Council for Quality Health Care

Misa Sakaguchi
General Manager
Department of Adverse Event Prevention
Japan Council for Quality Health Care

We would like to express our deepest gratitude to everyone for your continued understanding and cooperation in regard to the running of this project.

This project provides various information based on medical near-miss/adverse event information reported by medical institutions. We are hereby pleased to publish our 2021 Annual Report, which summarizes the medical near-miss/adverse event information reported between January and December 2021. We would like to express our sincere gratitude to all those who reported events to this project at a time when medical institutions have been severely impacted by COVID-19.

This Annual Report provides the collated results for the year and an outline of the themes highlighted in the quarterly reports. We hope that staff at medical institutions, especially those in charge of medical safety management, will be able to put those parts of this report relevant to the circumstances of their particular medical institution to good use. The JQ also hopes that by reading this Annual Report, the general public—as recipients of medical care—will gain an understanding of the current state of medical adverse events and medical near-misses, as well as efforts by medical institutions and the medical community to prevent their recurrence.

A total of 1,575 medical institutions were participating in this project as of the end of 2021. By engaging with this project and reporting events that can serve as a useful reference for other medical institutions, participating medical institutions provide us with information crucial to promoting medical safety nationwide, which we can share with a wider audience. While the number of voluntarily participating medical institutions has gradually increased, we would be grateful to secure the participation of even more medical institutions.

The JQ received 5,243 reports of medical adverse event information in 2021. As the number of reports received from medical institutions subject to reporting requirements is increasing year on year, we believe that the practice of reporting such events is becoming firmly established. On the other hand, the number of reports from voluntarily participating medical institutions remains lower than the number from medical institutions subject to reporting requirements. We would like to encourage voluntarily participating medical institutions to take the next step in participating in this project by beginning to report medical adverse event information. The focus of medical adverse event information reporting under this project is not dictated by whether or not the event was due to incorrect medical care or management, or even the extent of the impact, but also encompasses events that can help to prevent medical adverse events at medical institutions or ensure that they do not recur. Accordingly, we would greatly appreciate your cooperation in the appropriate reporting of events that fall within this scope.

Quarterly and annual reports and Medical Safety Information bulletins can be downloaded from the project website, which also has a function enabling users to search for events. Statistics that do not appear in this Annual Report can also be found on the website. We hope that you will read this Annual Report and the website, and use the information provided by this project to promote medical safety.

This project will continue to strive to provide useful information to prevent medical adverse events and ensure that they do not recur and would therefore greatly appreciate your understanding and cooperation in this endeavor.

I

2021 Annual Report

I 2021 Annual Report

1. Number of Registered Medical Institutions and Current Reporting Status

A total of 1,575 medical institutions were participating in this project as of the end of 2021. Diagrams providing a breakdown of the number of registered medical institutions can be found in "II-1 Status of Participation in the Project to Collect Medical Near-miss/Adverse Event Information," including the number of medical institutions reporting medical adverse event information and the number reporting medical near-miss events. These diagrams show basic data concerning the status of participation in this project and this information is updated on the website as required. It can be accessed via the "List of Registered Medical Institutions" link on the website.

A total of 5,243 reports of medical adverse event information were submitted between January and December 2021, the period covered by this Annual Report. Medical institutions subject to reporting requirements reported 4,674 of these, while voluntarily participating medical institutions reported 569. Fig. I-1 shows the number of reported events in past 10 years. As the project continues to receive around the same number of reports as the previous year, if not more, we believe that the practice of reporting medical adverse events is becoming firmly established.

Fig. I-1 Number of Reports of Medical Adverse Event Information and Number of Medical Institutions

Year		2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Number of reports	Mandatory	2,535	2,708	2,911	3,374	3,428	3,598	4,030	4,049	4,321	4,674
	Voluntary	347	341	283	280	454	497	535	483	481	569
	Total	2,882	3,049	3,194	3,654	3,882	4,095	4,565	4,532	4,802	5,243
Number of medical institutions	Mandatory	273	274	275	275	276	276	274	274	273	273
	Voluntary	653	691	718	743	755	773	797	812	834	857
	Total	926	965	993	1,018	1,031	1,049	1,071	1,086	1,107	1,130

For reference, Fig. I-2 shows the scope of events reported as medical adverse event information. As can be seen from (3), the scope encompasses events that can help to prevent medical adverse events at medical institutions or ensure that they do not recur, irrespective of whether or not the event was due to incorrect medical care or management, or the degree of effect on the patient.

Fig. I-2 Scope of Events Reported as Medical Adverse Event Information

(1) Apparent errors in treatment or management that resulted in the patient's death or mental or physical disability, or required unexpected treatment, treatment to an unexpected extent, or other medical procedure.

(2) Unapparent errors in treatment or management that resulted in the patient's death or mental or physical disability, or required unexpected treatment, treatment to an unexpected extent, or other medical procedure (including events possibly associated with treatment or management provided; limited to unexpected events).

(3) Other than those described in (1) and (2), information conducive to the prevention of medical adverse events and their recurrence at medical institutions.

In addition to the tables shown in the chapter "II Aggregate Reports" in this Annual Report, we recommend that you also refer to the website, which carries tables not published in the Annual Report, such as "Professional Experience of the Person Involved," "Clinical Department Involved," "Location of the Occurrence," and "Nature of Event × Severity of Event." Clicking on the "Statistics Menu" button on the website brings up a list of annual and quarterly tables, which users can browse and download.

2. Collection of Follow-Up Information Concerning Medical Adverse Events: Overview of On-site Visits

Where we deem it necessary to obtain more detailed facts concerning reported events from the medical institutions concerned, we make written inquiries and, if cooperation is forthcoming, undertake on-site visits. In 2021, we made 96 written inquiries to medical institutions and received 92 responses. Due to the COVID-19 pandemic, we were unable to carry out on-site visits in 2021.

3. Analysis of Events

1) Themes Analyzed

As shown in Fig. I-3, this project analyzes two types of theme: (1) themes selected for comprehensive analysis of both medical adverse event information and medical near-miss event information relevant to the theme collected over a six-month period; and (2) themes selected from medical adverse event information reported during the period under analysis in the quarterly report, which are then used in analyzing past events. In 2021, the themes selected for the first category were "Events Related to Residents," "Events Related to Chemotherapy Administered in Outpatient Chemotherapy Rooms," and "Events Related to Patient Mix-Up." Details of relevant medical near-miss event information were collected and the results of analysis were published in the 65th to 68th Quarterly Reports. In the second category, six themes were highlighted. Similar events were highlighted and the analysis published along with the summary of each event, background and causal factors, and improvement measures reported by the medical institution concerned. Information relating to such matters as the drugs or medical devices involved was also provided, as appropriate.

Fig. I-3 Themes Analyzed

Themes Analyzed	Quarterly Report No.
【1】 Themes selected for comprehensive analysis of both medical adverse event information and medical near-miss event information relevant to the theme collected over a six-month period	
[1] Events Related to Residents (2)	65th
[2] Events Related to Chemotherapy Administered in Outpatient Chemotherapy Rooms (1)	66th
[3] Events Related to Chemotherapy Administered in Outpatient Chemotherapy Rooms (2)	67th
[4] Events Related to Patient Mix-Up (1)	68th
【2】 Themes selected from medical adverse event information reported during the period under analysis in the quarterly report and used in analyzing past events	
[1] Events Involving Administration of Wrong Drug after Mix-up between Silece and Serenace Injection	65th
[2] Events Involving Incorrect Prescription of Meylon Injection 7%/8.4% 250 mL Preparation	
[3] Events Related to Handling and Management of Tracheostomy Tubes with Speech Functions and Speaking Valves	
[4] Events Involving Interruptions to Continuous Administration Due to Delays in Replacing Catecholamine Preparations	66th
[5] Events Related to Medical Device-Related Pressure Ulcers (MDRPU)	67th
[6] Events Related to COVID-19 (2021)	68th

2) Analysis of Recurrent and Similar Events

Some similar events continue to be reported even after information about medical adverse events has been provided in Quarterly Reports and Medical Safety Information, so repeated warnings are required. Accordingly, starting with the 18th Quarterly Report, we added a section entitled "Recurrence of Events and Occurrence of Similar Events" and, since the 50th Quarterly Report, have continued to analyze these events in the section "Analysis of Recurrent and Similar Events." This analysis highlights a number of themes that were the subject of reports after we had provided information about events of a similar nature and looks at trends in the reported number of recurrent or similar events after the provision of information, as well as providing details of the summary of event and specific improvement measures reported by the medical institutions concerned.

Fig. I-4 List of Analysis of Recurrent and Similar Events

Title	Quarterly Report No.
Wrong pick-up of syringe containing drug (Medical Safety Information No.15)	65th
Events relating to pathology (24th Quarterly Report) —Contamination with Another Pathology Test Specimen—	
Confusion between total product amount and content of active ingredient (Medical Safety Information No.9)	66th
Magnetic material (e.g. metal products) taken in the MRI room (Medical Safety Information No.10, No.94 (1st Follow-up Report))	
Left-Right Mix-Up When Inserting a Thoracostomy Tube (Medical Safety Information No.99)	
Provision of Food to Which the Patient was Allergic (Medical Safety Information No.69)	67th
Events Related to External Prescriptions (58th Quarterly Report)	68th

4. Medical Safety Information

Since December 2006, the project has provided Medical Safety Information to promote the prevention of the occurrence/recurrence of medical adverse events through the provision of information that ought to be made common knowledge. Medical Safety Information is designed to be user-friendly for medical professionals in busy clinical environments. Specifically, the volume of information is narrowed down to keep the length to around two pages of A4, with illustrations and tables provided for maximum visual impact. Medical Safety Information is sent out once a month by fax to registered medical institutions participating in the Project to Collect, Analyze, and Provide Medical Adverse Event Information and the Project to Collect, Analyze, and Provide Medical Near-Miss Information, and is also published on the website. In addition, to share this information with a wider audience, we also send it by fax free of charge to non-participating hospitals that ask to receive it. Medical Safety Information is faxed on the day of publication, enabling medical institutions to receive, circulate, and act on the information without delay.
In 2021, we compiled and published Medical Safety Information No. 170–181 (Fig. I-5). Fig. I-6 shows the recurrent and similar events most commonly reported in 2021 in relation to matters previously highlighted in Medical Safety Information No.1 to No.181.

Fig. I-5 Medical Safety Information released in 2021

Month of information supply	No.	Title
January	No.170	Provision of Unsuitable Food to a Patient with Impaired Chewing/Swallowing Function
February	No.171	Reactivation of Hepatitis B Due to Immunosuppression/Chemotherapy
March	No.172	Medical Safety Information Released in 2020
April	No.173	Tenfold Error in Flow Rate of Infusion Pump, etc.
May	No.174	Failure to Inject Enteral Nutrient after Administering Insulin
June	No.175	Medical Safety Information Highlighted in Quarterly Reports in 2020
July	No.176	Disconnection of Ventilator Circuit Tubing
August	No.177	Accidental Ingestion of PTP Sheets (2nd Follow-up Report) Attachment: For Users of Oral Medication
September	No.178	Burn while Bathing a Newborn or Infant
October	No.179	Contamination with Another Patient's Pathology Test Specimen
November	No.180	Incorrect Prescription of Meylon Injection 250 mL Preparation
December	No.181	Resected Organ/Tissue Remaining after Performing Laparoscopic Surgery

Fig. I-6 Most Commonly Reported Recurrent and Similar Events Previously the Subject of Medical Safety Information

No.	Title	Number of Events
No.54	Accidental removal of the endotracheal/tracheostomy tube when changing positions	19
No.63 No.138	Inadequate Checks Concerning Diagnostic Imaging Reports Inadequate Checks Concerning Diagnostic Imaging Reports (1st Follow-up Report)	17
No.58	Rupture of the subcutaneous port and catheter	15
No.47	Mix-up of the tooth extraction site	14
No.80 No.142	Urethral Damage Caused by an Indwelling Bladder Catheter Urethral Damage Caused by an Indwelling Bladder Catheter (1st Follow-up Report)	12
No.152	Gauze Remaining After Surgery (1) —Gauze Count—	11
No.176	Disconnection of Ventilator Circuit Tubing	11
No.48 No.146	Failure to check oxygen remaining Inadequate checks of Oxygen Remaining (1st Follow-up Report)	9
No.10 No.94	Magnetic material (e.g. metal products) taken in the MRI room Magnetic Material (e.g. Metal Products) Taken in the MRI Room (1st Follow-up Report)	8
No.57 No.82 No.177	Accidental ingestion of PTP sheets Accidental ingestion of PTP sheets (1st Follow-up Report) Accidental ingestion of PTP sheets (2nd Follow-up Report)	8
No.153	Gauze Remaining After Surgery (2) —Checking the X-ray Image—	8
No.7	Extravascular leakage in pediatric patients	7
No.78	Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions	7
No.132	Patient Falls While Using the Overbed Table for Support	7
No.4 No.68	Drug mix-up Drug mix-up (1st Follow-up Report)	6
No.99	Left-Right Mix-Up When Inserting a Thoracostomy Tube	6
No.137	Burns When Using a Heat Pack	6
No.147	Injury from a Wheelchair Footrest	6
No.149	Operation/Examination Postponed Due to Delays in Stopping Drugs	6
No.150	Forgetting to Check the Pathologic Diagnosis Report —Upper Gastrointestinal Endoscopy—	6

5. Current Status of the Project

The chapter "V Current Status of the Project" provides various information, including details of the improvements made to the project website in 2021, and information about the publication of English-language editions of the Annual Report and Medical Safety Information. It also outlines our dissemination of information overseas.

II

Aggregate Reports

II Aggregate Reports

1. Status of Participation in the Project to Collect Medical Near-miss/Adverse Event Information

The Project to Collect Medical Near-miss/Adverse Event Information consists of two projects, the Project to Collect, Analyze, and Provide Medical Adverse Event Information and the Project to Collect, Analyze, and Provide Medical Near-miss Event Information.

The medical institutions participating in each project as of December 31, 2021 are shown below.

Fig. II-1-1 Registration Status of Medical Institutions Participating in Each Project

Registration status			Project to Collect, Analyze, and Provide Medical Near-miss Event Information						Total	
			Participating				Not participating			
			Number of occurrences and medical near-miss event information		Only number of occurrences					
Project to Collect, Analyze, and Provide Medical Adverse Event Information	Required	Participating	123	516	84	334	66	280	273	1,130
	Voluntary	Participating	393		250		214		857	
		Not participating	162		283		—		445	
Total			678		617		280		1,575	
			1,295							

The current reporting status for each project is shown in 2. Project to Collect, Analyze, and Provide Medical Adverse Event Information and 3. Project to Collect, Analyze, and Provide Medical Near-miss Event Information.

2. Project to Collect, Analyze, and Provide Medical Adverse Event Information

The Project to Collect, Analyze, and Provide Medical Adverse Event Information gathers medical adverse event information from medical institutions subject to reporting requirements and also from voluntarily participating medical institutions that ask to participate in this project.

[1] Registered Medical Institutions

The number of medical institutions subject to reporting requirements and voluntarily participating medical institutions participating in the Project to Collect, Analyze, and Provide Medical Adverse Event Information as of December 31, 2021 is shown below. Reasons for the fluctuation in the number of medical institutions include opening/closure and consolidation of hospitals as well as change of classification of the parent organization.

Fig. II-2-1 Number of Medical Institutions Subject to Reporting Requirements and Voluntarily Participating Medical Institutions

Parent organization		Medical institutions subject to reporting requirements(Note 1)	Voluntarily participating medical institutions(Note 2)
Government	National University Corporation, etc.	45	1
	National Hospital Organization	140	0
	National Research and Development Agencies	8	0
	National Hansen's Disease Sanatorium	13	0
	Japan Organization of Occupational Health and Safety	0	29
	Japan Community Health care Organization	0	41
	Other national organizations	0	0
Municipality	Prefecture	2	25
	City/village	0	96
	Japan Association of Municipal and Prefectural Municipality Colleges and Universities	9	2
	Local independent administrative institutions	1	24
Parent organization of public medical institution other than municipality	Japan Red Cross	0	55
	Saiseikai Imperial Gift Foundation	0	21
	Hokkaido Social Welfare Association	0	2
	National Welfare Federation of Agricultural Cooperatives	0	19
	National Health Insurance Association Federation	0	1
	Health Insurance Union and their associations	0	2
	Mutual Aid Associations and their associations	0	10
	National Health Insurance Society	0	0
Corporation	School juridical organization	54	20
	Healthcare corporation	0	356
	Charitable organization	1	51
	Company	0	11
	Other corporation	0	33
Individual practitioner		0	58
Total		273	857

(Note 1) As of the end of December 2021, details of the medical institutions subject to reporting requirements (273 institutions) are as follows:
A. National Research and Development Agencies and National Hansen's Disease Sanatorium 22 institutions
B. National Hospital Organizations 140 institutions
C. University hospitals governed by the School Education Act (not including branch hospitals) 110 institutions
D. Special Functioning Hospitals (including those categorized as A, B or C above) 87 institutions
(Note 2) Voluntarily participating medical institutions are those participating in the project other than medical institutions subject to reporting requirements.

[2] Number of Reports

(1) Number of Monthly Reports

The number of monthly reports made by medical institutions subject to reporting requirements and voluntarily participating medical institutions between January 1 and December 31, 2021 is shown below. There were 5,243 reports in 2021.

Fig. II-2-2 Number of Monthly Reports Made by Medical Institutions Subject to Reporting Requirements and Voluntarily Participating Medical Institutions

	2021												Total
	January	February	March	April	May	June	July	August	September	October	November	December	
Number of reports made by medical institutions subject to reporting requirements	303	320	474	312	335	418	319	336	403	463	447	544	4,674
Number of reports made by voluntarily participating medical institutions	66	31	31	58	31	38	65	45	60	74	40	30	569
Number of medical institutions subject to reporting requirements	273	273	273	273	273	274	274	274	274	274	273	273	—
Number of voluntarily participating medical institutions	836	837	840	844	847	849	853	854	853	856	856	857	—

(2) Medical Adverse Event Reporting Status

A. Reporting status of medical institutions subject to reporting requirements

Among medical institutions subject to reporting requirements, the number of reporting medical institutions subject to reporting requirements and the number of reports made by the parent organization between January 1 and December 31, 2021 are shown in Fig. II-2-3, the number of reports made since the launch of the project by the parent organization is shown in Fig. II-2-4, reports by the number of beds are shown in Fig. II-2-5, and reports by region are shown in Fig. II-2-6. In addition, the number of reporting medical institutions in the same period by number of reports are shown in Fig. II-2-7. Figures for the number of medical institutions subject to reporting requirements may not correspond to those shown in other tables, due to changes during the collection period, such as the accreditation of medical institutions as Special Functioning Hospitals or the abolition of medical institutions. As of December 31, 2021, the number of medical institutions subject to reporting requirements was 273, and the total number of beds at those institutions was 138,150.

Fig. II-2-3 Number of Reporting Medical Institutions Subject to Reporting Requirements and Reports Made by the Parent Organization

Parent organization		Number of medical institutions (As of December 31, 2021)	Number of reporting medical institutions	Number of reports
			January to December, 2021	January to December, 2021
Government	National University Corporation, etc.	45	45	1,310
	National Hospital Organization	140	130	1,496
	National Research and Development Agencies	8	8	139
	National Hansen's Disease Sanatorium	13	11	45
Municipality	Prefecture	12	10	387
	City/village			
	Japan Association of Municipal and Prefectural Municipality Colleges and Universities			
	Local independent administrative institutions			
Corporation	School juridical organization	54	38	1,164
	Charitable organization	1	1	133
Total		273	243	4,674

Fig. II-2-4 Number of Reports Made by Medical Institutions Subject to Reporting Requirements by the Parent Organization (Accumulated Total)

Parent organization		Number of reports
		October 2004 to December 2021
Government	National University Corporation, etc.	11,808
	National Hospital Organization	18,586
	National Research and Development Agencies	1,773
	National Hansen's Disease Sanatorium	537
Municipality	Prefecture	3,445
	City/village	
	Japan Association of Municipal and Prefectural Municipality Colleges and Universities	
	Local independent administrative institutions	
Corporation	School juridical organization	11,034
	Charitable organization	344
Total		47,527

Fig. II-2-5 Number of Reporting Medical Institutions Subject to Reporting Requirements and Reports Made by Number of Beds

Number of beds	Number of medical institutions (As of December 31, 2021)	Number of reporting medical institutions	Number of reports
		January to December, 2021	January to December, 2021
0-19 beds	0	0	0
20-49 beds	14	6	20
50-99 beds	4	3	6
100-149 beds	7	4	23
150-199 beds	9	6	28
200-249 beds	13	12	77
250-299 beds	16	12	94
300-349 beds	32	29	269
350-399 beds	18	17	172
400-449 beds	28	26	300
450-499 beds	15	15	245
500-549 beds	9	8	59
550-599 beds	8	8	120
600-649 beds	27	27	684
650-699 beds	8	7	327
700-749 beds	11	10	252
750-799 beds	3	3	94
800-849 beds	12	12	475
850-899 beds	4	4	241
900-999 beds	13	12	388
1000 beds or more	22	22	800
Total	273	243	4,674

Fig. II-2-6 Number of Reporting Medical Institutions Subject to Reporting Requirements and Number of Reports by Region

Region	Number of medical institutions (As of December 31, 2021)	Number of reporting medical institutions	Number of reports
		January to December, 2021	January to December, 2021
Hokkaido	9	8	57
Tohoku	25	24	298
Kanto/Koshinetsu	85	73	1,641
Tokai/Hokuriku	37	31	565
Kinki	36	33	490
Chugoku/Shikoku	35	32	790
Kyushu/Okinawa	46	42	833
Total	273	243	4,674

Fig. II-2-7 Number of Medical Institutions Subject to Reporting Requirements by Number of Reports

Number of reports	Number of reporting medical institutions (As of December 31, 2021)
0	31
1	15
2	10
3	10
4	12
5	7
6	17
7	15
8	6
9	10
10	9
11-20	74
21-30	21
31-40	5
41-50	6
51-100	19
101-150	5
151-200	1
200 or above	0
Total	273

B. Reporting status of voluntarily participating medical institutions

The number of voluntarily participating medical institutions and reports made by those institutions between January 1 and December 31, 2021 by the parent organization are shown in Fig. II-2-8 and the number of reports made since the launch of the project by the parent organization is shown in Fig. II-2-9.

Fig. II-2-8 Number of Reporting Voluntarily Participating Medical Institutions and Number of Reports by the Parent Organization

Parent organization	Number of medical institutions (As of December 31, 2021)	Number of reporting medical institutions	Number of reports
		January to December, 2021	January to December, 2021
Government	71	13	48
Municipality	147	27	200
Public medical institution	110	21	70
Corporation	471	71	248
Individual practitioner	58	2	3
Total	857	134	569

Fig. II-2-9 Number of Reports Made by Voluntarily Participating Medical Institutions by the Parent Organization (Accumulated Total)

Parent organization	Number of reports
	October 2004 to December 2021
Government	394
Municipality	1,650
Public medical institution	1,101
Corporation	2,744
Individual practitioner	11
Total	5,900

[3] Details of Reports Made by Registered Medical Institutions

This Annual Report carries some of the results compiled on the basis of medical adverse event information reports from registered medical institutions (medical institutions subject to reporting requirements and voluntarily participating medical institutions) between January 1 and December 31, 2021. Each table is compiled on the basis of the options available in the Medical Adverse Event Information Report Input Items.

Fig. II-2-10 Job Title of the Person Involved

Job title of the person involved	Number of reports
Doctor	3,362
Dentist	114
Nurse	2,730
Assistant nurse	12
Pharmacist	59
Clinical engineer	39
Midwife	18
Nursing assistant	27
Radiological technologist	47
Clinical technologist	32
Registered dietitian	2
Dietitian	0
Cook/kitchen staff	2
Physical therapist (PT)	43
Occupational therapist (OT)	20
Speech -language –hearing therapist (ST)	1
Medical technologist	0
Dental hygienist	11
Dental technologist	0
Others	64
Total	6,583

* The person involved is a person determined by the medical institution to have been involved in the event occurred; more than 1 person may have been involved.

Fig. II-2-11 Summary of Event

Summary of event	Number of events	%
Drugs	415	7.9
Blood transfusion	9	0.2
Treatment/procedure	1,772	33.8
Medical device, etc.	150	2.9
Drainage tubes or other tubes	400	7.6
Examination	279	5.3
Nursing care	1,593	30.4
Others	625	11.9
Total	5,243	100.0

* Regarding percentages, the totals may not become 100.0 due to rounding to the first decimal place.

Fig. II-2-12 Severity of Event

Severity of event	Number of events	%
Death	407	7.8
High potential of residual disability	500	9.5
Low potential of residual disability	1,440	27.5
No potential of residual disability	1,449	27.6
No disability	1,300	24.8
Unknown	147	2.8
Total	5,243	100.0

* Severity of event is not necessarily associated with occurrence of event or negligence.
* "Unknown" includes indefinite outcome at the time of reporting (within 2 weeks).
* Regarding percentages, the totals may not become 100.0 due to rounding to the first decimal place.

Fig. II-2-13 Events Encouraged to Be Reported

Events encouraged to be reported	Number of events	%
Accident due to use of contaminated drug/material/ biologic product	15	0.3
Death or disability due to nosocomial infection	1	0
Suicide or suicide attempt of patient	65	1.2
Disappearance of inpatient	3	0.1
Burn of patient	55	1.0
Electric shock of patient	0	0
Death or disability of patient due to facility fire	4	0.1
Handling over of infant to wrong parent	0	0
No applicable option	5,100	97.3
Total	5,243	100.0

* Regarding percentages, the totals may not become 100.0 due to rounding to the first decimal place.

Fig. II-2-14 Clinical Department

Clinical department	Number of events	%
Internal medicine	467	7.1
Anesthesiology	264	4.0
Cardiovascular medicine	466	7.0
Neurology	159	2.4
Respiratory medicine	329	5.0
Gastrointestinal medicine	486	7.3
Hematology	107	1.6
Circulatory surgery	42	0.6
Allergy	7	0.1
Rheumatism	21	0.3
Pediatrics	282	4.3
General surgery	496	7.5
Orthopedics	708	10.7
Plastic surgery	76	1.1
Cosmetic surgery	1	0
Neurosurgery	253	3.8
Respiratory surgery	157	2.4
Cardiovascular surgery	286	4.3
Pediatric surgery	33	0.5
Pain clinic	5	0.1
Dermatology	56	0.8
Urology	214	3.2
Venereology	0	0
Proctology	5	0.1
Gynecology/Obstetrics	112	1.7
Obstetrics	28	0.4
Gynecology	86	1.3
Ophthalmology	72	1.1
Otolaryngology	132	2.0
Psychosomatic medicine	4	0.1
Psychiatry	236	3.6
Rehabilitation	30	0.5
Radiology	120	1.8
Dentistry	61	0.9
Orthodontics	4	0.1
Pediatric dentistry	5	0.1
Dental/oral surgery	67	1.0
Unknown	22	0.3
Others	716	10.8
Total	6,615	100.0

* "Clinical department" may be more than one.
* Regarding percentages, the totals may not become 100.0 due to rounding to the first decimal place.

3. Project to Collect, Analyze, and Provide Medical Near-Miss Event Information

The information collected in the Project to Collect, Analyze, and Provide Medical Near-Miss Event Information consists of the information on the number of occurrences and medical near-miss event information. The number of occurrences about them is collected by all medical institutions that wish to participate in the Project to Collect, Analyze, and Provide Medical Near-Miss Event Information. This Annual Report provides collated results for the number of medical near-miss events occurring and reported.

[1] Participating Medical Institutions

The number of medical institutions participating in the Project to Collect, Analyze, and Provide Medical Near-Miss Event Information as of December 31, 2021 is shown below.

Fig. II-3-1 Number of Participating Medical Institutions in the Project to Collect, Analyze, and Provide Medical Near-Miss Event Information

Parent organization		Participating medical institutions	Participating medical institutions for medical near-miss event information reporting
Government	National University Corporation etc.	29	18
	National Hospital Organization	117	68
	National Research and Development Agencies	5	3
	National Hansen's Disease Sanatorium	12	4
	Japan Organization of Occupational Health and Safety	29	24
	Japan Community Health care Organization	43	23
	Other national organizations	0	0
Municipality	Prefecture	30	17
	City/village	140	75
	Japan Association of Municipal and Prefectural Municipality Colleges and Universities	11	6
	Local independent administrative institutions	26	12
Parent organization of public medical institution other than municipality	Japan Red Cross	82	47
	Saiseikai Imperial Gift Foundation	22	11
	Hokkaido Social Welfare Association	1	1
	National Welfare Federation of Agricultural Cooperatives	21	8
	National Health Insurance Association Federation	2	0
	Health Insurance Union and their associations	1	0
	Mutual Aid Associations and their associations	22	12
	National Health Insurance Society	1	1
Corporation	School juridical organization	50	35
	Healthcare corporation	476	226
	Charitable organization	55	24
	Company	9	2
	Other corporation	47	20
Individual practitioner		64	41
Total		1,295	678

[2] Information on the Number of Occurrences

The reports of the information on the number of occurrences between January 1 and December 31, 2021 are shown below.

Fig. II-3-2 Information on the Number of Occurrences

Items	Erroneous medical procedures				Total
	Not performed			Performed	
	Effects (if actions in question had been done)				
	Patients would have died or had serious conditions	Patients would have required intensive procedure/treatment	Patients would have required minor procedure/treatment or would not have required any procedure/treatment		
(1) Drugs	1,683	8,410	105,719	205,619	321,431
(2) Blood transfusion	90	285	2,089	3,847	6,311
(3) Treatment/procedure	536	2,667	15,912	44,391	63,506
(4) Medical device, etc.	352	1,171	12,183	21,716	35,422
(5) Drainage tubes or other tubes	400	2,623	30,454	115,271	148,748
(6) Examination	678	2,155	31,781	59,207	93,821
(7) Nursing care	613	4,117	67,646	148,442	220,818
(8) Others	638	2,426	53,958	63,842	120,864
Total	4,990	23,854	319,742	662,335	1,010,921
Re-posted					
[1] Events involving name or dosage form of drug	277	2,144	5,879	13,405	21,705
[2] Events caused by drug	781	4,602	41,535	80,748	127,666
[3] Events caused by medical device, etc.	248	796	5,444	12,207	18,695
[4] Current theme	228	617	5,092	6,801	12,738

Number of reporting medical institutions	646
Total number of beds	243,316

[3] Number of Medical Near-miss Event Information

(1) Status of Monthly Reports for Medical Near-miss Event Information

The number of monthly reports for medical near-miss event information between January 1 and December 31, 2021 is shown below.

Fig. II-3-3 Number of Monthly Reports for Medical Near-miss Event Information

	2021												Total
	January	February	March	April	May	June	July	August	September	October	November	December	
Number of medical near-miss event information	5,294	1,435	1,511	4,598	1,036	778	3,916	1,526	1,313	6,224	745	1,403	29,779
Number of participating medical institutions for medical near-miss event information reporting	668	668	668	671	673	674	676	678	676	677	677	678	—

(2) Summary of Event

Fig. II-3-4 Summary of Event

Summary of event	Number of events	%
Drugs	10,104	33.9
Blood transfusion	141	0.5
Treatment/procedure	1,446	4.9
Medical device, etc.	1,049	3.5
Drainage tubes or other tubes	4,565	15.3
Examination	2,571	8.6
Nursing care	5,972	20.1
Others	3,931	13.2
Total	29,779	100.0

* Regarding percentages, the totals may not become 100.0 due to rounding to the first decimal place.

III

Current Analysis of Medical Near-miss/Adverse Event Information

III Current Analysis of Medical Near-miss/Adverse Event Information

Both medical adverse event information and medical near-miss event information have been collected in the project launched in 2004. Since 2005, medical adverse event information and medical near-miss event information covered by individual themes have been comprehensively analyzed.

1. Project Overview

[1] Information to be Analyzed

Events with information related to predetermined themes were selected from among the medical adverse event information and medical near-miss event information reported during the period under analysis in each quarterly report and then analyzed. In addition, if additional analysis was deemed necessary, past events outside the period under analysis in the quarterly report were selected and analyzed in the same way, after first determining the period to be examined.

[2] Analysis System

At meetings held once a month or so, Expert Analysis Groups consisting of medical professionals involved in medical safety and experts in safety management review the main medical adverse event information reported through this project and consider the content of themes for analysis. Theme-specific Expert Analysis Groups are established to conduct analysis, based on the field of expertise involved in the events. This department then compiles these analyses and, after review by the Comprehensive Evaluation Panel, publishes information about them.

[3] Workshop

We held workshops for participating medical institutions, to inform them about the current status of the project and enhance the quality of reports.

(1) FY2021 Workshop on Using Information Concerning Medical Safety

1) **Date:** Saturday November 20, 2021
2) **Format:** Online
3) **Target participants:** Staff of registered medical institutions participating in this project
4) **Program**
   i) About the Project to Collect Medical Near-miss/Adverse Event Information: From Reporting Events to Providing and Using Information
   ii) Use of Medical Safety Information at Our Hospital (1)
   iii) Use of Medical Safety Information at Our Hospital (2)
   iv) Status of Medical Safety Information Use and Related Issues: Findings from a Questionnaire Distributed to Hospitals Nationwide
5) **Number of participants**
   311 people took part.

(2) FY2021 RCA Workshop

1) **Date:** Saturday February 26, 2022
2) **Format:** Online
3) **Target participants:** Staff of registered medical institutions participating in this project
4) **Program**

i) Outline of the Project to Collect Medical Near-miss/Adverse Event Information and Current Status of Reporting
ii) Outline of Root Cause Analysis
iii) Key Points When Using Root Cause Analysis to Analyze Adverse Events (including an exercise)

5) Number of participants
530 people took part.

2. Collection of Follow-Up Information on Medical Adverse Events

When an Expert Analysis Group determines that more detailed information from the medical institution is required for analysis, it makes written inquiries to the reporting medical institution or, if the institution agrees to cooperate, conducts an on-site visit. The details of additional information provided are utilized in considering medical safety measures.

[1] Collection of Follow-Up Information in Writing

In 2021, we made 96 written inquiries concerning medical adverse event information and received 92 responses. Figure III-2-1 shows an overview of the events concerning which follow-up information was requested.

Fig. III-2-1 Overview of Written Requests for Follow-up Information

Overview of the event	Number of events
Drugs	54
Blood transfusions	0
Treatment/procedure	11
Medical device, etc.	4
Drainage tubes or other tubes	3
Examination	8
Nursing care	8
Others	8
Total	96

[2] Collection of Follow-Up Information via On-site Visits

Due to the COVID-19 pandemic, we were unable to carry out any on-site visits in 2021.

3. Themes Analyzed

[1] Selection of Themes for Information to be Analyzed

This project endeavors to use the data reported to provide information that will help to prevent medical adverse events and ensure that they do not recur. Accordingly, themes are selected for information to be analyzed and events associated with that theme are analyzed and examined. The themes have been selected based on expert opinions and in light of 1) generality/universality, 2) event frequency, 3) effect on patients, 4) preventability, and 5) ability to serve as an object lesson.

This project's Quarterly Reports analyze two types of theme: (1) themes selected for comprehensive analysis of both medical adverse event information and medical near-miss event information relevant to the theme collected over a six-month period; and (2) themes selected from medical adverse event information reported during the period under analysis in the quarterly report, which are then used in analyzing past events.

[2] Overview of Themes Analyzed

Fig. III-3-1 lists the themes analyzed in the 65th to 68th Quarterly Reports, which covered the period under analysis for events reported in 2021.

Fig. III-3-1 Themes Analyzed

Themes Analyzed	Quarterly Report No.
[1] Themes selected for comprehensive analysis of both medical adverse event information and medical near-miss event information relevant to the theme collected over a six-month period	
[1] Events Related to Residents (2)	65th
[2] Events Related to Chemotherapy Administered in Outpatient Chemotherapy Rooms (1)	66th
[3] Events Related to Chemotherapy Administered in Outpatient Chemotherapy Rooms (2)	67th
[4] Events Related to Patient Mix-Up (1)	68th
[2] Themes selected from medical adverse event information reported during the period under analysis in the quarterly report and used in analyzing past events	
[1] Events Involving Administration of Wrong Drug after Mix-up between Silece and Serenace Injection	65th
[2] Events Involving Incorrect Prescription of Meylon Injection 7%/8.4% 250 mL Preparation	
[3] Events Related to Handling and Management of Tracheostomy Tubes with Speech Functions and Speaking Valves	
[4] Events Involving Interruptions to Continuous Administration Due to Delays in Replacing Catecholamine Preparations	66th
[5] Events Related to Medical Device-Related Pressure Ulcers (MDRPU)	67th
[6] Events Related to COVID-19 (2021)	68th

4. Analysis of Recurrent and Similar Events

A section entitled Individual Theme Review appeared in the 1st to 49th Quarterly Reports for this project and was renamed Themes Analyzed from the 50th Quarterly Report. Highlighting a specific theme, this section analyzes and examines events related to that theme. Based on previously profiled themes and the like, the project also publishes Medical Safety Information, which provides information that should be common knowledge. The Analysis of Recurrent and Similar Events section of the quarterly reports highlights recurrent and similar events to those previously highlighted in Themes Analyzed and Medical Safety Information, providing information once more.

[1] Overview of the Analysis of Recurrent and Similar Events

The Analysis of Recurrent and Similar Events section of the 65th to 68th Quarterly Reports, which analyzed events reported in 2021, highlighted major events about which reports had been received again, looking at trends in the number of recurrent or similar events that occurred between the provision of information and the period under analysis in the quarterly report in question, and also detailing specific improvement measures reported by the medical institutions concerned. Figure III-4-1 lists the types of events analyzed in the quarterly reports.

Fig. III-4-1 List of Analysis of Recurrent and Similar Events

Title	Quarterly Report No.
Wrong pick-up of syringe containing drug (Medical Safety Information No.15)	65th
Events relating to pathology (24th Quarterly Report) —Contamination with Another Pathology Test Specimen—	
Confusion between total product amount and content of active ingredient (Medical Safety Information No.9)	66th
Magnetic material (e.g. metal products) taken in the MRI room (Medical Safety Information No.10, No.94 (1st Follow-up Report))	
Left-Right Mix-Up When Inserting a Thoracostomy Tube (Medical Safety Information No.99)	
Provision of Food to Which the Patient was Allergic (Medical Safety Information No.69)	67th
Events Related to External Prescriptions (58th Quarterly Report)	68th

IV

Medical Safety Information

IV Medical Safety Information

In December 2006, this Project began to prepare Medical Safety Information bulletins for both medical institutions participating in the project and the wider public, to provide information about which knowledge should be particularly widespread. This Medical Safety Information is provided by fax and also via the project website.

1. Summary

[1] Objective

The objective of this service is to provide participating medical institutions with information that ought to be made common knowledge, based on the information reported to the Project to Collect Medical Near-Miss/ Adverse Event Information, to assist in preventing the occurrence/recurrence of medical adverse events.

[2] Medical Institutions Receiving Information by Fax

Medical Safety Information is provided to about 6,000 medical institutions in the following three categories:

1) Medical institutions subject to reporting requirements as well as voluntarily participating medical institutions in the Project to Collect, Analyze, and Provide Medical Adverse Event Information

2) Participating medical institutions in the Project to Collect, Analyze, and Provide Medical Near-miss Event Information

3) Hospitals other than those in categories 1) and 2) above, which have requested that information be provided by fax

2. Medical Safety Information Released in 2021

Medical Safety Information bulletins No.170 to No.181 were issued between January and December 2021.

Fig. IV-2-1 Medical Safety Information released in 2021

Month of information supply	No.	Title
January	No.170	Provision of Unsuitable Food to a Patient with Impaired Chewing/Swallowing Function
February	No.171	Reactivation of Hepatitis B Due to Immunosuppression/Chemotherapy
March	No.172	Medical Safety Information Released in 2020
April	No.173	Tenfold Error in Flow Rate of Infusion Pump, etc.
May	No.174	Failure to Inject Enteral Nutrient after Administering Insulin
June	No.175	Medical Safety Information Highlighted in Quarterly Reports in 2020
July	No.176	Disconnection of Ventilator Circuit Tubing
August	No.177	Accidental Ingestion of PTP Sheets (2nd Follow-up Report) Attachment: For Users of Oral Medication
September	No.178	Burn while Bathing a Newborn or Infant
October	No.179	Contamination with Another Patient's Pathology Test Specimen
November	No.180	Incorrect Prescription of Meylon Injection 250 mL Preparation
December	No.181	Resected Organ/Tissue Remaining after Performing Laparoscopic Surgery

V

Current Status of the Project

V Current Status of the Project

This chapter describes the project's achievements in 2021, along with activities and outcomes associated with the project. It mainly provides a summary of the "V Current Status of the Project" section of the 65th to 68th Quarterly Reports.

1. Dissemination of Information about the Project

The project publishes Quarterly Reports, the Annual Report, and monthly Medical Safety Information bulletins, as well as providing a database of events and holding workshops. The pamphlet "Project Activities and How to Participate" (https://www.med-safe.jp/pdf/business_pamphlet.pdf) provides a user-friendly introduction to the project and the information provided on the website (available in Japanese only).

2. Changes to the Design of the Event Reporting System

1) Top Page

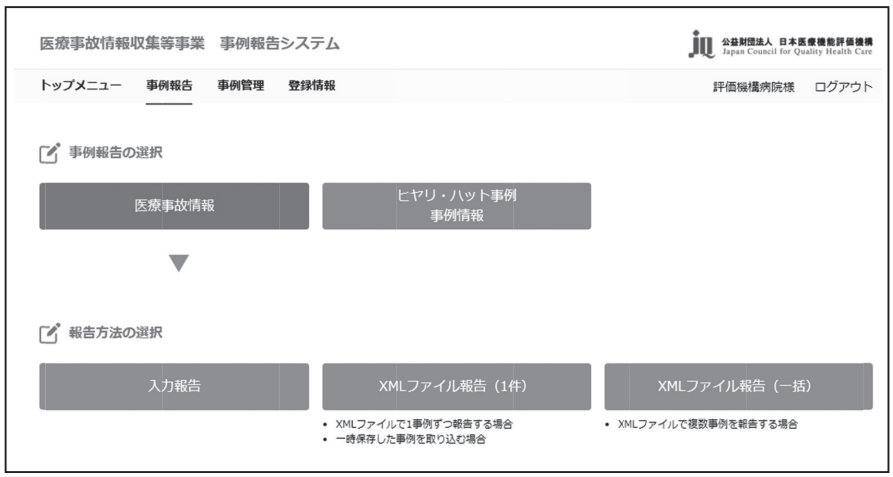
In order to improve visibility, we have changed the design of the system via which registered medical institutions report medical adverse event information and medical near-miss events. As well as altering the positions of the Event Report, Event Management, and Registration Details buttons, we have indicated the projects in which the facility is participating in a more easily comprehensible way. We have also added a Latest Information column to provide notifications about publications and the like.

Fig. V-1　Top Page of the Event Reporting System

2) Event Reporting Page

We have changed the page so that users first select the information to be reported and then select the reporting method.

Fig. V-2 Event Reporting Page



3. Pharmaceutical Companies' Use of Output from the Project to Collect Medical Near-miss/Adverse Event Information to Prevent Drug Mix-Up

This project issued warnings about events involving drug mix-up due to similar drug names in Medical Safety Information No.4 "Drug mix-up" (March 2007) and Medical Safety Information No.68 "Drug mix-up (1st Follow-up Report)." Since then, such events have repeatedly been highlighted in the Analysis of Recurrent and Similar Events section of the Quarterly Reports. Pharmaceutical companies have themselves also issued warnings about similarities in brand names. Some of the warning documents issued by pharmaceutical companies are based on events published as part of this project or the Project to Collect and Analyze Pharmaceutical Near-Miss Event Information, which is run by the Division of Adverse Event Prevention. As such, specific warnings continue to be provided in an effort to prevent medical adverse events, using information about events reported to these two projects. Fig. V-3 provides a summary of warnings issued by pharmaceutical companies that were published in Quarterly Reports in 2021. Please refer to the relevant Quarterly Report for details.

Fig. V-3 Warnings from Pharmaceutical Companies Highlighted in the Project's Quarterly Reports

Quarterly Report No.	Warning	Date of Issue	Company Name
66th	Caution Regarding Mix-ups Due to the Similarity in Brand Names Between Tenelia® and Ternelin®	April 2021	Mitsubishi Tanabe Pharma Corporation Daiichi Sankyo Co., Ltd. Sun Pharma Japan Ltd.

4. Publication of the English-language Editions of the 2020 Annual Report and Medical Safety Information No.168-179

An English-language edition of the Annual Report has been compiled and published on the website every year since the 2005 Annual Report. In February 2022, we published the English translation of this project's 2020 Annual Report, entitled "Project to Collect Medical Near-miss/Adverse Event Information 2020 Annual Report." It can be viewed and downloaded from our website. We also publish English-language versions of the Medical Safety Information for readers overseas. They are made available worldwide via Healthcare Excellence Canada's Global Patient Safety Alerts project. The English editions of Medical Safety Information No.168 to No.179 were published in February 2022 (Fig. V-4) and can be found on the website's English page. We hope that you will make use of them.

Fig. V-4 English Editions of Medical Safety Information Published in February 2022

No.	Title in English
No.168	Failure to Check Oxygen Tank Valve Was Open
No.169	Omission from Prescription/Order When Continuing Prescription for Current Medicines Brought in at Hospitalization
No.170	Provision of Unsuitable Food to a Patient with Impaired Chewing/Swallowing Function
No.171	Reactivation of Hepatitis B Due to Immunosuppression/ Chemotherapy
No.172	Medical Safety Information Released in 2020
No.173	Tenfold Error in Flow Rate of Infusion Pump, etc.
No.174	Failure to Inject Enteral Nutrient after Administering Insulin
No.175	Medical Safety Information Highlighted in Quarterly Reports in 2020
No.176	Disconnection of Ventilator Circuit Tubing
No.177	Accidental Ingestion of PTP Sheets (2nd Follow-up Report) Attachment: For Users of Oral Medication
No.178	Burn while Bathing a Newborn or Infant
No.179	Contamination with Another Patient's Pathology Test Specimen

5. Workshops

The project holds workshops for registered medical institutions to supply them with more in-depth knowledge about the information provided by the project and ways of using that information at their institution. Due to the impact of COVID-19, these workshops have been held online since FY2020. In FY2021, we held two workshops: the Workshop on Using Information Concerning Medical Safety took place on Saturday, November 20, 2021, while the RCA Workshop was held on Saturday, February 26, 2022.

6. Dissemination of Information Overseas

Due to growing attention from overseas, the JQ and this project have many opportunities to give lectures. We will continue to participate in shaping international trends in patient safety and strive to exert a positive influence through the JQ's projects focused on the quality and safety of medical care and Japanese achievements in the field of patient safety activities. Details of the specific topics covered at each conference can be found in the Quarterly Report in which it was covered (Fig. V-5).

Fig. V-5 International Conferences Covered in Quarterly Reports Published in 2021

Quarterly Report No.	Conference	Schedule	Location
65th	The 5th Quality Health Care Conference and Exhibition, Policy and Practice: A Partnership for Better Outcomes	November 11-13, 2019	Amman, Jordan
66th	Second meeting for the collaborative design of the Global Knowledge Sharing Platform for Patient Safety	December 2-3, 2019	Florence, Italy
	G20 Patient Safety Representative Roundtable Session	December 7-9, 2019	Riyadh, Saudi Arabia
67th	WHO Global Consultation "A Decade of Patient Safety 2020-2030": Formulating the Global Patient Safety Action Plan"	February 24-26, 2020	Geneva, Switzerland

Date of publication: September 30, 2022

Project to Collect Medical Near-miss/Adverse Event Information

2021 Annual Report

Edited and published by: Division of Adverse Event Prevention,
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ISBN978-4-910861-24-1