Project to Collect Medical Near-miss/ Adverse Event Information 2022 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 2022 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 2022 Annual Report, which summarizes the medical near-miss/adverse event information reported between January and December 2022. 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 1,618 medical institutions were participating in this project as of the end of 2022. 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 5,313 reports of medical adverse event information in 2022. 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

2022 Annual Report

I 2022 Annual Report

1. Number of Registered Medical Institutions and Current Reporting Status

A total of 1,618 medical institutions were participating in this project as of the end of 2022. 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 5,313 reports of medical adverse event information were submitted between January and December 2022, the period covered by this Annual Report. Medical institutions subject to reporting requirements reported 4,631 of these, while voluntarily participating medical institutions reported 682. 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 Registered Medical Institutions

Year		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Number of reports	Mandatory	2,708	2,911	3,374	3,428	3,598	4,030	4,049	4,321	4,674	4,631
	Voluntary	341	283	280	454	497	535	483	481	569	682
	Total	3,049	3,194	3,654	3,882	4,095	4,565	4,532	4,802	5,243	5,313
Number of medical institutions	Mandatory	274	275	275	276	276	274	274	273	273	275
	Voluntary	691	718	743	755	773	797	812	834	857	883
	Total	965	993	1,018	1,031	1,049	1,071	1,086	1,107	1,130	1,158

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 2022, we made 97 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 2022.

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; 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 2022, the themes selected for the first category were "Events Related to Patient Mix-Up" and "Events Related to Double-Checks." Details of relevant medical near-miss event information were collected and the results of analysis were published in the 69th to 72nd Quarterly Reports. In the second category, two 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	
[1] Events Related to Patient Mix-Up (2)	69th
[2] Events Related to Patient Mix-Up (3)	70th
[3] Events Related to Patient Mix-Up (4)	71st
[4] Events Related to Double-Checks (1)	72nd
(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 a Bed Leaving Sensor Not Functioning Because of Forgetting to Switch on the Power or an Error in the Method of Use	71st
[2] Events Related to Unit Selection on Syringe Pumps	72nd

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.
Administration of Contraindicated Drug (Medical Safety Information No.86)	69th
Chest Drain Left Open to Air (Medical Safety Information No.133)	
Administration of 10 times proper dosage to pediatric patients (Medical Safety Information No.29)	70th
Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions (Medical Safety Information No.78)	
Air Embolism Due to a Central Venous Line Left Open (Medical Safety Information No.130)	71st
Tubing misconnection of ventilator circuit (Medical Safety Information No.24)	72nd

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 2022, we compiled and published Medical Safety Information No. 182–193 (Fig. I-5). Fig. I-6 shows the recurrent and similar events most commonly reported in 2022 in relation to matters previously highlighted in Medical Safety Information No.1 to No.193.

Fig. I-5 Medical Safety Information released in 2022

Month of information supply	No.	Title
January	No.182	Drug Mix-up between Serenace Injection and Silece
February	No.183	Confusion between Product Volume and Active Ingredient Dosage (1st Follow-up Report)
March	No.184	Medical Safety Information Released in 2021
April	No.185	Use of a Used Endoscope on Another Patient
May	No.186	Failure to Check Blood Test Results before Administering Anticancer Drugs
June	No.187	Medical Safety Information Highlighted in Quarterly Reports in 2021
July	No.188	Fitting of Elastic Stockings to Patients with Arteriosclerosis Obliterans of the Lower Limbs
August	No.189	Burn Caused by a Hot Towel
September	No.190	Selection of Wrong Connection for Indwelling Bladder Catheter
October	No.191	Local Injection of High-Concentration Adrenaline Due to Container Mix-Up
November	No.192	Pressure Ulcers Caused by Medical Devices
December	No.193	Wrong Drug Administration Route (1st Follow-up Report)

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

No.	Title	Number of Events
No.152	Gauze Remaining After Surgery (1) —Gauze Count—	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)	13
No.153	Gauze Remaining After Surgery (2) —Checking the X-ray Image—	13
No.176	Disconnection of Ventilator Circuit Tubing	13
No.54	Accidental removal of the endotracheal/tracheostomy tube when changing positions	11
No.63 No.138	Inadequate Checks Concerning Diagnostic Imaging Reports Inadequate Checks Concerning Diagnostic Imaging Reports (1st Follow-up Report)	11
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)	10
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)	9
No.47	Mix-up of the tooth extraction site	9
No.58	Rupture of the subcutaneous port and catheter	8
No.29	Administration of 10 times proper dosage to pediatric patients	7
No.59	Burns Due to Incorrect Handling of an Electrosurgical Pencil	7
No.7	Extravascular leakage in pediatric patients	6
No.48 No.146	Failure to check oxygen remaining Inadequate checks of Oxygen Remaining (1st Follow-up Report)	6
No.86	Administration of Contraindicated Drug	6
No.15	Wrong pick-up of syringe containing drug	5
No.90	Catheter or Tube Erroneously Cut with Scissors	5
No.99	Left-Right Mix-Up When Inserting a Thoracostomy Tube	5
No.132	Patient Falls While Using the Overbed Table for Support	5
No.144	Failure to Submit a Pathology Specimen	5
No.171	Reactivation of Hepatitis B Due to Immunosuppression/Chemotherapy	5

5. Current Status of the Project

The chapter “V Current Status of the Project” provides various information, including details of the dissemination of information about this project and initiatives for World Patient Safety Day, responses by pharmaceutical companies using output from this project, 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, 2022 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	529	83	341	69	288	275	1,158
	Voluntary	Participating	406		258		219		883	
		Not participating	162		298		—		460	
Total			691		639		288		1,618	
			1,330							

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, 2022 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	9	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	3	24
	City/village	0	100
	Japan Association of Municipal and Prefectural Municipality Colleges and Universities	9	3
	Local independent administrative institutions	1	25
Parent organization of public medical institution other than municipality	Japan Red Cross	0	55
	Saiseikai Imperial Gift Foundation	0	22
	Hokkaido Social Welfare Association	0	2
	National Welfare Federation of Agricultural Cooperatives	0	20
	National Health Insurance Association Federation	0	1
	Health Insurance Union and their associations	0	2
	Mutual Aid Associations and their associations	0	12
	National Health Insurance Society	0	0
Corporation	School juridical organization	54	20
	Healthcare corporation	0	367
	Charitable organization	1	50
	Company	0	11
	Other corporation	0	35
Individual practitioner		0	63
Total		275	883

(Note 1) As of the end of December 2022, details of the medical institutions subject to reporting requirements (275 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) 88 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, 2022 is shown below. There were 5,313 reports in 2022.

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	368	419	561	377	362	392	259	324	410	356	336	467	4,631
Number of reports made by voluntarily participating medical institutions	63	48	47	48	22	29	54	117	81	70	44	59	682
Number of medical institutions subject to reporting requirements	273	273	273	273	273	274	274	274	274	274	274	275	—
Number of voluntarily participating medical institutions	856	856	859	868	870	875	878	878	876	878	882	883	—

(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, 2022 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, 2022, the number of medical institutions subject to reporting requirements was 275, and the total number of beds at those institutions was 138,375.

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, 2022)	Number of reporting medical institutions	Number of reports
			January to December, 2022	January to December, 2022
Government	National University Corporation, etc.	45	43	1,183
	National Hospital Organization	140	126	1,460
	National Research and Development Agencies	9	7	161
	National Hansen's Disease Sanatorium	13	13	53
Municipality	Prefecture	13	12	503
	City/village			
	Japan Association of Municipal and Prefectural Municipality Colleges and Universities			
	Local independent administrative institutions			
Corporation	School juridical organization	54	36	1,124
	Charitable organization	1	1	147
Total		275	238	4,631

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 2022
Government	National University Corporation, etc.	12,991
	National Hospital Organization	20,046
	National Research and Development Agencies	1,934
	National Hansen's Disease Sanatorium	590
Municipality	Prefecture	3,948
	City/village	
	Japan Association of Municipal and Prefectural Municipality Colleges and Universities	
	Local independent administrative institutions	
Corporation	School juridical organization	12,158
	Charitable organization	491
Total		52,158

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, 2022)	Number of reporting medical institutions	Number of reports
		January to December, 2022	January to December, 2022
0-19 beds	0	0	0
20-49 beds	13	5	12
50-99 beds	5	1	1
100-149 beds	8	4	19
150-199 beds	9	6	33
200-249 beds	13	11	48
250-299 beds	17	12	105
300-349 beds	33	29	206
350-399 beds	16	15	147
400-449 beds	30	28	285
450-499 beds	13	13	256
500-549 beds	9	9	76
550-599 beds	10	8	200
600-649 beds	26	25	634
650-699 beds	8	8	314
700-749 beds	11	10	338
750-799 beds	3	3	90
800-849 beds	12	12	420
850-899 beds	4	4	203
900-999 beds	14	14	526
1000 beds or more	21	21	718
Total	275	238	4,631

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, 2022)	Number of reporting medical institutions	Number of reports
		January to December, 2022	January to December, 2022
Hokkaido	9	9	63
Tohoku	25	20	278
Kanto/Koshinetsu	86	70	1,692
Tokai/Hokuriku	38	32	499
Kinki	36	32	605
Chugoku/Shikoku	35	33	817
Kyushu/Okinawa	46	42	677
Total	275	238	4,631

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, 2022)
0	37
1	11
2	10
3	10
4	25
5	6
6	16
7	11
8	7
9	13
10	10
11-20	57
21-30	22
31-40	10
41-50	8
51-100	16
101-150	4
151-200	2
200 or above	0
Total	275

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, 2022 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, 2022)	Number of reporting medical institutions	Number of reports
		January to December, 2022	January to December, 2022
Government	71	16	35
Municipality	152	41	253
Public medical institution	114	25	66
Corporation	483	85	326
Individual practitioner	63	2	2
Total	883	169	682

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 2022
Government	429
Municipality	1,903
Public medical institution	1,167
Corporation	3,070
Individual practitioner	13
Total	6,582

[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, 2022. 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	3,505
Dentist	78
Nurse	2,945
Assistant nurse	6
Pharmacist	65
Clinical engineer	28
Midwife	38
Nursing assistant	16
Radiological technologist	46
Clinical technologist	29
Registered dietitian	1
Dietitian	3
Cook/kitchen staff	1
Physical therapist (PT)	46
Occupational therapist (OT)	13
Speech -language –hearing therapist (ST)	2
Medical technologist	0
Dental hygienist	5
Dental technologist	0
Others	61
Total	6,888

* 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	410	7.7
Blood transfusion	13	0.2
Treatment/procedure	1,724	32.4
Medical device, etc.	150	2.8
Drainage tubes or other tubes	417	7.8
Examination	249	4.7
Nursing care	1,653	31.1
Others	697	13.1
Total	5,313	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	425	8.0
High potential of residual disability	545	10.3
Low potential of residual disability	1,524	28.7
No potential of residual disability	1,470	27.7
No disability	1,171	22.0
Unknown	178	3.4
Total	5,313	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	4	0.1
Death or disability due to nosocomial infection	4	0.1
Suicide or suicide attempt of patient	66	1.2
Disappearance of inpatient	13	0.2
Burn of patient	64	1.2
Electric shock of patient	0	0
Death or disability of patient due to facility fire	0	0
Handling over of infant to wrong parent	1	0
No applicable option	5,161	97.1
Total	5,313	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	461	6.7
Anesthesiology	335	4.9
Cardiovascular medicine	476	6.9
Neurology	149	2.2
Respiratory medicine	300	4.4
Gastrointestinal medicine	463	6.8
Hematology	110	1.6
Circulatory surgery	22	0.3
Allergy	6	0.1
Rheumatism	23	0.3
Pediatrics	272	4.0
General surgery	539	7.9
Orthopedics	717	10.5
Plastic surgery	82	1.2
Cosmetic surgery	0	0
Neurosurgery	341	5.0
Respiratory surgery	108	1.6
Cardiovascular surgery	297	4.3
Pediatric surgery	31	0.5
Pain clinic	6	0.1
Dermatology	71	1.0
Urology	285	4.2
Venereology	0	0
Proctology	1	0
Gynecology/Obstetrics	113	1.6
Obstetrics	31	0.5
Gynecology	104	1.5
Ophthalmology	77	1.1
Otolaryngology	134	2.0
Psychosomatic medicine	0	0
Psychiatry	251	3.7
Rehabilitation	48	0.7
Radiology	132	1.9
Dentistry	27	0.4
Orthodontics	2	0
Pediatric dentistry	3	0
Dental/oral surgery	67	1.0
Unknown	14	0.2
Others	761	11.1
Total	6,859	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, 2022 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.	28	17
	National Hospital Organization	116	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	45	25
	Other national organizations	0	0
Municipality	Prefecture	31	16
	City/village	144	78
	Japan Association of Municipal and Prefectural Municipality Colleges and Universities	11	6
	Local independent administrative institutions	30	13
Parent organization of public medical institution other than municipality	Japan Red Cross	82	47
	Saiseikai Imperial Gift Foundation	24	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	23	12
	National Health Insurance Society	1	1
Corporation	School juridical organization	50	35
	Healthcare corporation	495	232
	Charitable organization	55	25
	Company	9	2
	Other corporation	47	19
Individual practitioner		68	44
Total		1,330	691

[2] Information on the Number of Occurrences

The reports of the information on the number of occurrences between January 1 and December 31, 2022 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	1,162	8,485	112,610	201,010	323,267
(2) Blood transfusion	104	275	2,187	3,504	6,070
(3) Treatment/procedure	509	3,130	15,910	43,012	62,561
(4) Medical device, etc.	299	1,373	12,786	21,832	36,290
(5) Drainage tubes or other tubes	339	2,723	30,922	114,963	148,947
(6) Examination	386	2,715	34,254	58,114	95,469
(7) Nursing care	590	5,312	65,318	151,966	223,186
(8) Others	590	2,904	57,442	61,754	122,690
Total	3,979	26,917	331,429	656,155	1,018,480
Re-posted					
[1] Events involving name or dosage form of drug	156	1,856	5,379	14,012	21,403
[2] Events caused by drug	578	4,513	39,690	79,045	123,826
[3] Events caused by medical device, etc.	223	881	5,863	12,861	19,828
[4] Current theme	234	1,696	13,239	10,814	25,983

Number of reporting medical institutions	686
Total number of beds	257,976

[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, 2022 is shown below.

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

	2022												Total
	January	February	March	April	May	June	July	August	September	October	November	December	
Number of medical near-miss event information	4,917	1,070	1,373	3,901	1,779	1,374	5,117	1,205	4,093	4,882	1,044	1,102	31,857
Number of participating medical institutions for medical near-miss event information reporting	678	678	680	687	688	690	690	690	689	690	692	691	—

(2) Summary of Event

Fig. II-3-4 Summary of Event

Summary of event	Number of events	%
Drugs	12,681	39.8
Blood transfusion	119	0.4
Treatment/procedure	1,357	4.3
Medical device, etc.	1,374	4.3
Drainage tubes or other tubes	4,191	13.2
Examination	2,349	7.4
Nursing care	6,283	19.7
Others	3,503	11.0
Total	31,857	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) FY2022 RCA Workshop

1) **Date:** Saturday February 18, 2023
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**
   358 people took part.

(2) FY2022 Workshop on Medical Safety Initiatives Based on Collaboration between Medical Institutions and Health Insurance Pharmacies

(Jointly organized by the Project to Collect Medical Near-miss/Adverse Event Information and the Project to Collect and Analyze Pharmaceutical Near-Miss Event Information)

1) **Date:** Sunday March 5, 2023
2) **Format:** Online
3) **Target participants:** Staff of registered medical institutions participating in this project
   Staff of pharmacies participating in the Project to Collect and Analyze Pharmaceutical Near-Miss Event Information
4) **Program**
   i) Current Status and Issues of the Project to Collect Medical Near-miss/Adverse Event Information and the Project to Collect and Analyze Pharmaceutical Near-Miss Event Information
   ii) Medical Safety Initiatives within Medical Institutions and in the Community: What Medical Institutions Want from Pharmacies
   iii) Regional Medical Cooperation and Patient Safety: Ensuring Value in Information Sharing
   iv) Issues in Collaboration between Hospital and Community Pharmacies as Seen from Pharmaceutical Near-Miss Event Reports: Desirable Approaches to Information Sharing and Collaboration for Pharmaceutical Safety
5) **Number of participants**
   544 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 2022, we made 97 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	62
Blood transfusions	1
Treatment/procedure	10
Medical device, etc.	4
Drainage tubes or other tubes	8
Examination	6
Nursing care	5
Others	1
Total	**97**

[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 2022.

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; 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 69th to 72nd Quarterly Reports, which covered the period under analysis for events reported in 2022.

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	
[1] Events Related to Patient Mix-Up (2)	69th
[2] Events Related to Patient Mix-Up (3)	70th
[3] Events Related to Patient Mix-Up (4)	71st
[4] Events Related to Double-Checks (1)	72nd
(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 a Bed Leaving Sensor Not Functioning Because of Forgetting to Switch on the Power or an Error in the Method of Use	71st
[2] Events Related to Unit Selection on Syringe Pumps	72nd

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 69th to 72nd Quarterly Reports, which analyzed events reported in 2022, 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.
Administration of Contraindicated Drug (Medical Safety Information No.86)	69th
Chest Drain Left Open to Air (Medical Safety Information No.133)	
Administration of 10 times proper dosage to pediatric patients (Medical Safety Information No.29)	70th
Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions (Medical Safety Information No.78)	
Air Embolism Due to a Central Venous Line Left Open (Medical Safety Information No.130)	71st
Tubing misconnection of ventilator circuit (Medical Safety Information No.24)	72nd

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 2022

Medical Safety Information bulletins No.182 to No.193 were issued between January and December 2022.

Fig. IV-2-1 Medical Safety Information released in 2022

Month of information supply	No.	Title
January	No.182	Drug Mix-up between Serenace Injection and Silece
February	No.183	Confusion between Product Volume and Active Ingredient Dosage (1st Follow-up Report)
March	No.184	Medical Safety Information Released in 2021
April	No.185	Use of a Used Endoscope on Another Patient
May	No.186	Failure to Check Blood Test Results before Administering Anticancer Drugs
June	No.187	Medical Safety Information Highlighted in Quarterly Reports in 2021
July	No.188	Fitting of Elastic Stockings to Patients with Arteriosclerosis Obliterans of the Lower Limbs
August	No.189	Burn Caused by a Hot Towel
September	No.190	Selection of Wrong Connection for Indwelling Bladder Catheter
October	No.191	Local Injection of High-Concentration Adrenaline Due to Container Mix-Up
November	No.192	Pressure Ulcers Caused by Medical Devices
December	No.193	Wrong Drug Administration Route (1st Follow-up Report)

V

Current Status of the Project

V Current Status of the Project

This chapter describes the project's achievements in 2022, 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 69th to 72nd 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).

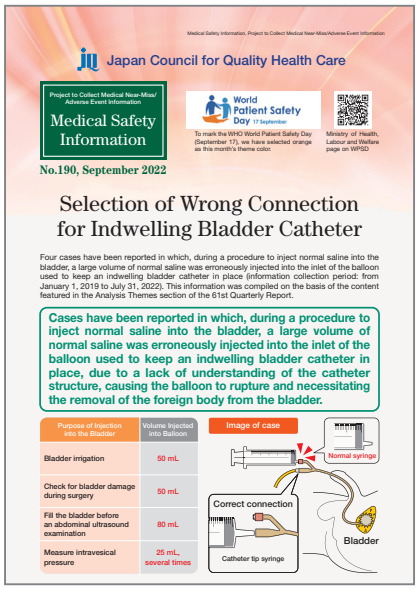
2. Initiatives for World Patient Safety Day

September 17 each year has been designated World Patient Safety Day by the World Health Organization (WHO). The purpose of World Patient Safety Day is to promote global solidarity and concerted action by WHO member countries to improve patient safety. The theme in FY2022 was medication safety, and the slogan was "medication without harm." Public awareness campaigns and the like are promoted both within Japan and overseas for World Patient Safety Day, including the illumination of buildings, landmarks, and monuments in orange, the color symbolizing the campaign. This project marked the event by changing the background color of Medical Safety Information No. 190 from the usual blue to orange in September 2022.

Fig. V-1 Medical Safety Information Issued by This Project

No.189 (issued in August 2022)

No.190 (issued in September 2022)



3. Use of Output from the Project to Collect Medical Near-miss/ Adverse Event Information

1) Responses by Pharmaceutical Companies to Assist in Preventing 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 based on events published as part of this project or the Project to Collect and Analyze Pharmaceutical Near-Miss Event Information.

2) Responses by Pharmaceutical Companies to Promote the Proper Use of Drugs

In Medical Safety Information No.158 "Administration of a Sustained-Release Preparation in Ground-Up Form" (January 2020), this project provided a warning about cases in which a sustained-release preparation was ground up and administered to a patient, with the result that the active ingredient was rapidly absorbed into the patient's body and affected them. Pharmaceutical companies have themselves also issued warnings about sustained-release preparations in ground-up form based on events published as part of this project or the Project to Collect and Analyze Pharmaceutical Near-Miss Event Information.

Fig. V-2 provides a summary of warnings issued by pharmaceutical companies that were published in Quarterly Reports in 2022. Please refer to the relevant Quarterly Report for details.

Fig. V-2 Warnings from Pharmaceutical Companies Highlighted in the Project's Quarterly Reports

Quarterly Report No.	Warning	Date of Issue	Company Name
71st	Caution Regarding Mix-ups Due to the Similarity in Brand Names Between Myslee® and Mystan®	July 2022	Astellas Pharma Inc. Sumitomo Pharma Co., Ltd.
72nd	Adalat® CR tablets 10 mg/20 mg/ 40 mg are a sustained-release preparation *They must not be split, ground up or chewed before being taken*	September 2022	Bayer Yakuhin, Ltd.

4. Publication of the English-language Editions of the 2021 Annual Report and Medical Safety Information No.180-191

An English-language edition of the Annual Report has been compiled and published on the website every year since the 2005 Annual Report. In March 2023, we published the English translation of this project's 2021 Annual Report, entitled "Project to Collect Medical Near-miss/Adverse Event Information 2021 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.180 to No.191 were published in March 2023 (Fig. V-3) and can be found on the website's English page. We hope that you will make use of them.

Fig. V-3 English Editions of Medical Safety Information Published in March 2023

No.	Title
No.180	Incorrect Prescription of Meylon Injection 250 mL Preparation
No.181	Resected Organ/Tissue Remaining after Performing Laparoscopic Surgery
No.182	Drug Mix-up between Serenace Injection and Silece
No.183	Confusion between Product Volume and Active Ingredient Dosage (1st Follow-up Report)
No.184	Medical Safety Information Released in 2021
No.185	Use of a Used Endoscope on Another Patient
No.186	Failure to Check Blood Test Results before Administering Anticancer Drugs
No.187	Medical Safety Information Highlighted in Quarterly Reports in 2021
No.188	Fitting of Elastic Stockings to Patients with Arteriosclerosis Obliterans of the Lower Limbs
No.189	Burn Caused by a Hot Towel
No.190	Selection of Wrong Connection for Indwelling Bladder Catheter
No.191	Local Injection of High-Concentration Adrenaline Due to Container Mix-Up

5. Workshops

The project holds workshops for registered medical institutions to inform them about the current status of the project and encourage high-quality reporting. Due to the impact of COVID-19, these workshops have been held online since FY2020. In FY2022, we held two workshops: the RCA Workshop took place on Saturday, February 18, 2023, while the Workshop on Medical Safety Initiatives Based on Collaboration between Medical Institutions and Health Insurance Pharmacies was held on Sunday, March 5, 2023 as a workshop jointly organized by the Project to Collect Medical Near-miss/Adverse Event Information and the Project to Collect and Analyze Pharmaceutical Near-Miss Event Information.

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. Fig. V-4 shows the international conferences covered in quarterly reports Published in 2022. Among the matters noted were the JQ's participation in the G20 Global Patient Safety Leaders Group, whose establishment was set out in the Declaration of the G20 Health Ministers put together by G20 Chair Saudi Arabia in 2020; the fact that the Japanese representative at the WHO Executive Board session held in January 2021 praised the effectiveness of incident reporting and learning systems, and stated that Japan had contributed to the preparation of the Patient Safety Incident Reporting and Learning System report published by the WHO in 2020; and the fact that, at the G7 event on patient safety, Patient Safety Incident Reporting and Learning System, which was hosted in November 2021 by the UK as G7 Chair, the Japanese representative highlighted Japan's efforts by stating that the establishment of a reporting and learning system at the national level had made it possible for all institutions to learn from patient safety incidents. Details of the specific topics covered at each conference can be found in the Quarterly Report in which it was covered.

Fig. V-4 International Conferences Covered in Quarterly Reports Published in 2022

Quarterly Report No.	Conference	Schedule	Location
69th	No Fault Compensation for Neonatal Cerebral Palsy Online Workshop on Compensation Investigation Prevention of Cerebral Palsy Malaysia	October 20-23, 2020	Malaysia
	The 8th National Quality Control Circle Competition for Chinese Hospital & International Summit for Quality and Safety in Healthcare	December 2020	People's Republic of China
	148th session of the WHO Executive Board	January 18-26, 2021	Swiss Confederation
70th	CAHO-ISQua International Webinar Series	January 5, 2021	Republic of India
	Australasian College of Health Service Management (Live Webcast)	March 3, 2021	The Commonwealth of Australia
	Italian Network on Safety in Healthcare: COVID-19 in nursing homes	March 5, 2021	Italian Republic
	WHO Global Patient Safety Network Webinar Series	March 5, 2021	Swiss Confederation
71st	21st HA National Forum, Hospital Accreditation Thailand	March 11, 2021	Kingdom of Thailand
	27th Regional Congress of the Perinatal Society of Malaysia	March 19, 2021	Malaysia
	Smart Healthcare Technology and Patient Safety International Conference	August 27, 2021	Taiwan
	12th Open Conference of the Collaborative Latin American Forum on Quality and Safety in Healthcare	October 22, 2021	Argentine Republic
	2021 Smart Healthcare & Patient Safety International Conference, Taichung Veterans Hospital	October 24, 2021	Taiwan
	2021 Taiwan Joint Conference in Healthcare: Asian Perspectives from Joint Commission Taiwan	November 4, 2021	Taiwan
72nd	SIGMED IV, organized by the CREST Association	November 11, 2021	Romania
	G7 event on patient safety: Patient Safety: from Vision to Reality	November 22, 2021	United Kingdom of Great Britain and Northern Ireland
	WHO Policy Makers Forum: Patient Safety Implementation	February 23-24, 2022	Swiss Confederation
	AACI Surveyors Program	March 26, 2022	United States of America

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Project to Collect Medical Near-miss/Adverse Event Information

2022 Annual Report

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