Project to Collect Medical Near-miss/ Adverse Event Information 2024 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. This year marks the 30th anniversary of our organization's establishment, on July 27, 1995. 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 Project to Collect Dental 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 published on our website 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 2024 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 quarterly and annual 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 2024 Annual Report, which provides the collated results for the year and an outline of the themes highlighted in the quarterly reports.

A total of 4,447 medical institutions were participating in this project as of the end of 2024. This division also operates the Project to Collect Dental Near-miss Event Information, which focuses on dental clinics and began registering participants and collecting information about events in October 2023. We have seen a substantial increase in the number of medical institutions participating in this project, as many of the dental clinics taking part in the Project to Collect Dental Near-miss Event Information have chosen to participate in this project as well.

The JQ received 5,911 reports of medical adverse event information in 2024. The number of reports from voluntarily participating medical institutions remains lower than the number from medical institutions subject to reporting requirements. 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. By reporting such events, participating medical institutions provide us with information crucial to promoting medical safety nationwide, which we can share with a wider audience. As the next step in participation, we would greatly appreciate participants' 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.

More than 20 years have passed since this project began in October 2004, and medical systems and the like have changed significantly over this time. In order to address the current climate surrounding medical care and put in place an environment that facilitates reporting by participating medical institutions, we have reviewed the items to be included in reports and enhanced the event reporting system. Since April 2025, we have been collecting information about events based on the new items for inclusion in reports.

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

2024 Annual Report

I 2024 Annual Report

1. Number of Registered Medical Institutions and Current Reporting Status

A total of 5,911 reports of medical adverse event information were submitted between January and December 2024, the period covered by this Annual Report. Medical institutions subject to reporting requirements reported 5,102 of these, while voluntarily participating medical institutions reported 809.

Fig. I-1 shows the number of reports of medical adverse event information and the number of registered medical institutions over the past 10 years. As the number of reports received each year from medical institutions subject to reporting requirements continues to be at least the same level as the previous year, we believe that the practice of reporting medical adverse events is becoming firmly established. On the other hand, the fact that the number of events reported by voluntarily participating medical institutions is lower than the number of events reported by medical institutions subject to reporting requirements and fluctuates from year to year appears to indicate a difference in awareness of reporting. However, as we believe that taking part in this project is an indication of proactive efforts to address medical safety, we would like to ask participating medical institutions for their continued cooperation in the appropriate reporting of events as the next step in their participation.

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

Year		2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Number of reports	Mandatory	3,374	3,428	3,598	4,030	4,049	4,321	4,674	4,631	5,183	5,102
	Voluntary	280	454	497	535	483	481	569	682	887	809
	Total	3,654	3,882	4,095	4,565	4,532	4,802	5,243	5,313	6,070	5,911
Number of medical institutions	Mandatory	275	276	276	274	274	273	273	275	275	270
	Voluntary	743	755	773	797	812	834	857	883	1,022	3,703
	Total	1,018	1,031	1,049	1,071	1,086	1,107	1,130	1,158	1,297	3,973

As of December 31, 2024, the number of medical institutions participating in this project stood at 4,447, with a total of 3,973 medical institutions participating in the reporting of medical adverse event information. The Japan Council for Quality Health Care's Division of Adverse Event Prevention, which runs this project, also operates the Project to Collect Dental Near-miss Event Information, which focuses on dental clinics and began registering participants and collecting information about events in October 2023. The number of medical institutions participating in this project has increased considerably, as many of the dental clinics taking part in the Project to Collect Dental Near-miss Event Information also registered to participate in the Project to Collect Medical Near-miss/Adverse Event Information at the same time.

We would like to request that dental clinics not only report events to the Project to Collect Dental Near-miss Event Information, which asks for information about events specific to the field of dental care, but also report events such as those that had a major impact to the Project to Collect Medical Near-miss/Adverse Event Information. As the Project to Collect Dental Near-miss Event Information provides information such as reports and a searchable database of events on its website, we hope that both dental clinics and hospitals with dental departments will make use of this information.

Fig. I-2 Classification of Participating Medical Institutions

Facility Classification	Number of Medical Institutions
Hospitals	1,537
Clinics (with beds)	59
Clinics (without beds)	99
Dental clinics	2,752
Total	**4,447**

*As of December 31, 2024

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.

For reference, Fig. I-3 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-3 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, the website 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."

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 2024, we made 106 written inquiries to medical institutions and received 103 responses. We asked four medical institutions for permission to carry out on-site visits regarding four events and carried out visits with the cooperation of all the medical institutions concerned. In particular, we believe that the on-site visits provide useful information for the promotion of medical safety, as it is possible to engage in more in-depth discussion of the details of the reported event by inquiring about the content of deliberations conducted within the institution after the report and to acquire information that it was not possible to glean at the time of the report. Section "III-2 [2] Collection of Follow-Up Information via On-site Visits" in this Annual Report provides an overview of on-site visits. Fig. I-4 provides details of on-site visits carried out in 2024.

Fig. I-4 List of On-site Visits

Visit	Type of event	Summary of event
1	Drugs	Event in which the tissue type of a patient with squamous cell lung carcinoma was misidentified and a nonsquamous cell carcinoma regimen was ordered and administered to the patient
2		Event in which a patient mix-up when calling patients into the outpatient chemotherapy room resulted in Patient Y's anticancer drug being administered to Patient X
3	Blood transfusion	Event in which RBC for Patient Y (type B) was erroneously brought into the operating theater for Patient X (type O) and administered to the patient
4	Examination	Event in which specimens became unidentifiable due to mislabeling when processing multiple urinary cytologic specimens

3. Analysis of Events

1) Themes Analyzed

As shown in Fig. I-5, 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 2024, the themes selected for the first category were "Events Related to Prescription Errors Around the Time of Discharge," "Events Related to Ward or Departmental Stock Drugs," and "Events Related to Gastrostomy/Enterostomy and Associated Catheter Change/Management." Details of relevant medical near-miss event information were collected and the results of analysis were published in the 77th to 80th Quarterly Reports. In the second category, one theme was 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-5 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 Prescription Errors Around the Time of Discharge (1)	77th
[2] Events Related to Ward or Departmental Stock Drugs (1)	78th
[3] Events Related to Ward or Departmental Stock Drugs (2)	79th
[4] Events Related to Gastrostomy/Enterostomy and Associated Catheter Change/Management	80th
【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 Delays to the Start of Treatment Based on Interpretation Results Despite the Diagnostic Imaging Report Being Marked "Read"	79th

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-6 List of Analysis of Recurrent and Similar Events

Title	Quarterly Report No.
Events Related to the Transceivers of Wireless Electrocardiogram Monitors (38th Quarterly Report)	77th
Events Related to Wrongly Inserted Gastric Tube (43rd Quarterly Report)	
Specimen Mix-up at Pathological Diagnosis (Medical Safety Information No.53)	78th
Burns Caused by a Pulse Oximeter Probe (Medical Safety Information No.161)	
Reactivation of Hepatitis B Due to Immunosuppression/Chemotherapy (Medical Safety Information No.171)	79th
Wrong Choice of Pneumococcal Vaccine Preparation (Medical Safety Information No.97)	80th
Events Related to Wrong-Site Procedures Due to Mix-ups between Left and Right During Examinations, Treatment and Other Procedures (55th Quarterly Report) —Left/Right Mix-up in Nerve Block Procedures—	

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 published on the project website once a month.

In 2024, we compiled and published Medical Safety Information No. 206–217 (Fig. I-7). Fig. I-8 shows the recurrent and similar events most commonly reported in 2024 in relation to matters previously highlighted in Medical Safety Information No.1 to No.217.

Fig. I-7 Medical Safety Information released in 2024

Month of information supply	No.	Title
January	No.206	Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions (1st Follow-up Report)
February	No.207	Use of Blood Purifiers Contraindicated in Patients Receiving ACE Inhibitors
March	No.208	Medical Safety Information released in 2023
April	No.209	Use of a Peripheral Vein to Administer an Infusion That Should Be Administered through a Central Vein
May	No.210	Blockage of Heat and Moisture Exchanger Due to Use in Combination with a Heated Humidifier
June	No.211	Medical Safety Information Highlighted in Quarterly Reports in 2023
July	No.212	Delayed Discovery of the Migration of an Open Drain into the Body
August	No.213	Error When Changing Syringe on Syringe Pump
September	No.214	Incorrect Handling of Open-System Three-Way Stopcock
October	No.215	Hypoglycemia Due to Insulin Administration When Patient's Meals Had Been Stopped
November	No.216	Ineffective Ventilation of a Patient with a Permanent Tracheostomy
December	No.217	Guidewire Breakage Due to Combined Use with a Metal Needle

Fig. I-8 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—	23
No.153	Gauze Remaining After Surgery (2) —Checking the X-ray Image—	22
No.47	Mix-up of the tooth extraction site	19
No.192	Pressure Ulcers Caused by Medical Devices	19
No.54	Accidental removal of the endotracheal/tracheostomy tube when changing positions	15
No.10 No.94 No.198	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) Magnetic Material (e.g. Metal Products) Taken in the MRI Room (2nd Follow-up Report)	12
No.63 No.138	Inadequate Checks Concerning Diagnostic Imaging Reports Inadequate Checks Concerning Diagnostic Imaging Reports (1st Follow-up Report)	12
No.7 No.203	Extravascular leakage in pediatric patients Extravascular leakage in pediatric patients (1st Follow-up Report)	9
No.197	Forgetting to Switch on the Bed Leaving Sensor	9
No.80 No.142	Urethral Damage Caused by an Indwelling Bladder Catheter Urethral Damage Caused by an Indwelling Bladder Catheter (2nd Follow-up Report)	8
No.137	Burns When Using a Heat Pack	8
No.58	Rupture of the subcutaneous port and catheter	7
No.116	Patient Mix-up in Drug Administration	7
No.132	Patient Falls While Using the Overbed Table for Support	7
No.171	Reactivation of Hepatitis B Due to Immunosuppression/Chemotherapy	7
No.176	Disconnection of Ventilator Circuit Tubing	7

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, the creation of new Medical Safety Information pages for specific settings, initiatives for World Patient Safety Day, Medical Safety Information produced as part of a joint project with the Pharmaceuticals and Medical Devices Agency (PMDA), and information about the publication of English-language editions of the Annual Report and Medical Safety Information. It also outlines questionnaires about the project and 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, 2024 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	122	556	83	367	65	3,050	270	3,973
	Voluntary	Participating	434		284		2,985		3,703	
		Not participating		159		315		–		474
Total				715		682		3,050		4,447
				1,397						

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, 2024 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.	44	2
	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	40
	Other national organizations	0	0
Municipality	Prefecture	3	25
	City/village	0	109
	Japan Association of Municipal and Prefectural Municipality Colleges and Universities	9	5
	Local independent administrative institutions	1	28
Parent organization of public medical institution other than municipality	Japan Red Cross	0	55
	Saiseikai Imperial Gift Foundation	0	24
	Hokkaido Social Welfare Association	0	2
	National Welfare Federation of Agricultural Cooperatives	0	24
	National Health Insurance Association Federation	0	1
	Health Insurance Union and their associations	0	2
	Mutual Aid Associations and their associations	0	14
	National Health Insurance Society	0	0
Corporation	School juridical organization	50	24
	Healthcare corporation	0	1,258
	Charitable organization	1	57
	Company	0	12
	Other corporation	0	47
Individual practitioner		0	1,945
Total		270	3,703

(Note 1) As of the end of December 2024, details of the medical institutions subject to reporting requirements (270 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) 105 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, 2024 is shown below. There were 5,911 reports in 2024.

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

	2024												Total
	January	February	March	April	May	June	July	August	September	October	November	December	
Number of reports made by medical institutions subject to reporting requirements	414	377	507	381	432	361	443	445	469	476	368	429	5,102
Number of reports made by voluntarily participating medical institutions	67	56	40	62	71	59	60	89	72	120	39	74	809
Number of medical institutions subject to reporting requirements	275	275	275	275	275	275	275	275	275	274	270	270	—
Number of voluntarily participating medical institutions	1,036	1,044	1,146	1,621	2,396	3,025	3,282	3,395	3,486	3,591	3,660	3,703	—

(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, 2024 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, 2024, the number of medical institutions subject to reporting requirements was 270, and the total number of beds at those institutions was 136,082.

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, 2024)	Number of reporting medical institutions	Number of reports
			January to December, 2024	January to December, 2024
Government	National University Corporation, etc.	44	43	1,581
	National Hospital Organization	140	127	1,439
	National Research and Development Agencies	9	8	177
	National Hansen's Disease Sanatorium	13	12	66
Municipality	Prefecture	13	11	581
	City/village			
	Japan Association of Municipal and Prefectural Municipality Colleges and Universities			
	Local independent administrative institutions			
Corporation	School juridical organization	50	38	1,143
	Charitable organization	1	1	115
Total		270	240	5,102

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 2024
Government	National University Corporation, etc.	16,069
	National Hospital Organization	23,071
	National Research and Development Agencies	2,262
	National Hansen's Disease Sanatorium	744
Municipality	Prefecture	5,059
	City/village	
	Japan Association of Municipal and Prefectural Municipality Colleges and Universities	
	Local independent administrative institutions	
Corporation	School juridical organization	14,507
	Charitable organization	731
Total		62,443

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, 2024)	Number of reporting medical institutions	Number of reports
		January to December, 2024	January to December, 2024
0-19 beds	0	0	0
20-49 beds	13	6	15
50-99 beds	4	0	0
100-149 beds	7	3	8
150-199 beds	10	7	32
200-249 beds	15	11	63
250-299 beds	16	15	134
300-349 beds	33	29	287
350-399 beds	13	13	129
400-449 beds	28	27	315
450-499 beds	14	13	217
500-549 beds	8	8	83
550-599 beds	10	9	179
600-649 beds	27	27	809
650-699 beds	8	8	319
700-749 beds	9	9	361
750-799 beds	4	4	99
800-849 beds	12	12	445
850-899 beds	4	4	187
900-999 beds	16	16	741
1,000 beds or more	19	19	679
Total	270	240	5,102

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, 2024)	Number of reporting medical institutions	Number of reports
		January to December, 2024	January to December, 2024
Hokkaido	9	8	97
Tohoku	25	23	352
Kanto/Koshinetsu	83	72	1,846
Tokai/Hokuriku	37	32	579
Kinki	35	30	751
Chugoku/Shikoku	35	34	829
Kyushu/Okinawa	46	41	648
Total	270	240	5,102

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, 2024)
0	30
1	13
2	8
3	15
4	14
5	8
6	9
7	9
8	10
9	11
10	8
11-20	61
21-30	31
31-40	9
41-50	3
51-100	24
101-150	7
151-200	0
200 or above	0
Total	270

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, 2024 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, 2024)	Number of reporting medical institutions	Number of reports
		January to December, 2024	January to December, 2024
Government	71	11	20
Municipality	167	40	328
Public medical institution	122	22	75
Corporation	1,398	108	377
Individual practitioner	1,945	8	9
Total	3,703	189	809

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 2024
Government	488
Municipality	2,610
Public medical institution	1,344
Corporation	3,811
Individual practitioner	25
Total	8,278

[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, 2024. 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	3,818
Dentist	113
Nurse	3,351
Assistant nurse	9
Pharmacist	76
Clinical engineer	44
Midwife	36
Nursing assistant	32
Radiological technologist	57
Clinical technologist	21
Registered dietitian	0
Dietitian	1
Cook/kitchen staff	6
Physical therapist (PT)	55
Occupational therapist (OT)	19
Speech -language –hearing therapist (ST)	2
Medical technologist	0
Dental hygienist	6
Dental technologist	0
Others	44
Total	7,690

* 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	475	8.0
Blood transfusion	19	0.3
Treatment/procedure	1,879	31.8
Medical device, etc.	190	3.2
Drainage tubes or other tubes	406	6.9
Examination	294	5.0
Nursing care	1,840	31.1
Others	808	13.7
Total	5,911	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	492	8.3
High potential of residual disability	694	11.7
Low potential of residual disability	1,769	29.9
No potential of residual disability	1,357	23.0
No disability	1,295	21.9
Unknown	304	5.1
Total	5,911	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	14	0.2
Death or disability due to nosocomial infection	0	0
Suicide or suicide attempt of patient	58	1.0
Disappearance of inpatient	21	0.4
Burn of patient	65	1.1
Electric shock of patient	0	0
Death or disability of patient due to facility fire	0	0
Handling over of infant to wrong parent	0	0
No applicable option	5,753	97.3
Total	5,911	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	433	5.8
Anesthesiology	302	4.0
Cardiovascular medicine	532	7.1
Neurology	171	2.3
Respiratory medicine	339	4.5
Gastrointestinal medicine	554	7.4
Hematology	113	1.5
Circulatory surgery	42	0.6
Allergy	5	0.1
Rheumatism	26	0.3
Pediatrics	294	3.9
General surgery	497	6.6
Orthopedics	742	9.9
Plastic surgery	70	0.9
Cosmetic surgery	0	0
Neurosurgery	372	5.0
Respiratory surgery	127	1.7
Cardiovascular surgery	299	4.0
Pediatric surgery	31	0.4
Pain clinic	5	0.1
Dermatology	73	1.0
Urology	302	4.0
Venereology	0	0
Proctology	1	0
Gynecology/Obstetrics	145	1.9
Obstetrics	35	0.5
Gynecology	110	1.5
Ophthalmology	86	1.1
Otolaryngology	168	2.2
Psychosomatic medicine	4	0.1
Psychiatry	280	3.7
Rehabilitation	63	0.8
Radiology	141	1.9
Dentistry	35	0.5
Orthodontics	2	0
Pediatric dentistry	4	0.1
Dental/oral surgery	91	1.2
Unknown	94	1.3
Others	923	12.3
Total	7,511	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, 2024 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	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	45	25
	Other national organizations	0	0
Municipality	Prefecture	30	15
	City/village	154	81
	Japan Association of Municipal and Prefectural Municipality Colleges and Universities	13	8
	Local independent administrative institutions	35	15
Parent organization of public medical institution other than municipality	Japan Red Cross	80	48
	Saiseikai Imperial Gift Foundation	26	12
	Hokkaido Social Welfare Association	2	1
	National Welfare Federation of Agricultural Cooperatives	22	8
	National Health Insurance Association Federation	2	0
	Health Insurance Union and their associations	2	1
	Mutual Aid Associations and their associations	22	11
	National Health Insurance Society	1	1
Corporation	School juridical organization	48	32
	Healthcare corporation	542	249
	Charitable organization	58	27
	Company	9	2
	Other corporation	49	21
Individual practitioner		66	41
Total		1,397	715

[2] Information on the Number of Occurrences

The reports of the information on the number of occurrences between January 1 and December 31, 2024 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	1,407	11,211	129,110	223,447	365,175
(2) Blood transfusion	108	335	2,891	4,398	7,732
(3) Treatment/procedure	700	4,273	20,472	49,159	74,604
(4) Medical device, etc.	390	1,727	16,055	25,499	43,671
(5) Drainage tubes or other tubes	379	3,625	35,155	120,798	159,957
(6) Examination	563	3,772	40,924	68,828	114,087
(7) Nursing care	821	7,530	79,556	172,530	260,437
(8) Others	939	3,847	72,161	69,736	146,683
Total	5,307	36,320	396,324	734,395	1,172,346
Re-posted					
[1] Events involving name or dosage form of drug	286	1,564	6,383	16,006	24,239
[2] Events caused by drug	812	4,856	44,099	77,854	127,621
[3] Events caused by medical device, etc.	241	938	7,220	14,216	22,615
[4] Current theme	66	286	1,441	5,163	6,956

Number of reporting medical institutions	808
Total number of beds	270,126

[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, 2024 is shown below.

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

	2024												Total
	January	February	March	April	May	June	July	August	September	October	November	December	
Number of medical near-miss event information	3,677	562	554	3,749	644	548	4,748	1,806	2,557	4,838	1,717	1,872	27,272
Number of participating medical institutions for medical near-miss event information reporting	789	794	881	1,255	1,839	2,315	2,500	2,591	2,662	2,742	2,755	715	—

* In December 2024, we deregistered dental clinics that had been taking part in the Project to Collect Medical Near-miss/Adverse Event Information's Project to Collect, Analyze, and Provide Medical Near-Miss Information, as dental clinics now participate in the Project to Collect Dental Near-Miss Event Information.

(2) Summary of Event

Fig. II-3-4 Summary of Event

Summary of event	Number of events	%
Drugs	9,534	35.0
Blood transfusion	133	0.5
Treatment/procedure	1,303	4.8
Medical device, etc.	1,085	4.0
Drainage tubes or other tubes	3,755	13.8
Examination	2,335	8.6
Nursing care	5,972	21.9
Others	3,155	11.6
Total	27,272	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.

FY2024 Workshop on Process Flows

1) **Date:** Saturday February 18, 2025
2) **Venue:** JQ
3) **Target participants:** Staff of registered medical institutions participating in this project
   i) Teams to consist of 3-4 people from each medical institution.
   ii) Teams must include someone who plays a part in medical safety at the medical institution, such as the person in charge of the Medical Safety Management Division, the Medical Safety Manager, or members of the Medical Safety Committee or Medical Safety Officers.
   iii) A person with experience of using some kind of technique for analyzing medical adverse events at the medical institution should be included.
   iv) As the workshop will involve preparing a process flow covering the process from prescribing an injection drug to an inpatient to dispensing, preparing, and administering it, teams must include a doctor or dentist, a nurse, and a pharmacist, without fail.

4) **Program**
   i) Lectures:
      a. The Significance of Process Flows
      b. Medical Safety and Process Flows
      c. Drawing up Process Flows
   ii) Practice: Participants completed process flows drawn up beforehand for their medical institution and used model cases to consider such matters as vulnerabilities in the processes.

5) Number of participants
A total of 40 people from 11 medical institutions 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 2024, we made 106 written inquiries concerning medical adverse event information and received 103 responses. Fig. III-2-1 shows an overview of the events concerning which inquiries were made.

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

Type of Event	Number of events
Drugs	44
Blood transfusions	1
Treatment/procedure	12
Medical device, etc.	11
Drainage tubes or other tubes	7
Examination	8
Nursing care	13
Others	10
Total	**106**

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

In 2024, we asked four medical institutions for permission to conduct on-site visits regarding four events and all granted their cooperation.

A list of on-site visits conducted in 2024 is provided in Fig. III-2-2, while an overview of one of these visits is provided in Fig. III-2-3.

Fig. III-2-2 List of On-site Visits

Visit	Type of Event	Summary of Event
1	**Drugs**	Event in which the tissue type of a patient with squamous cell lung carcinoma was misidentified and a nonsquamous cell carcinoma regimen was ordered and administered to the patient
2		Event in which a patient mix-up when calling patients into the outpatient chemotherapy room resulted in Patient Y's anticancer drugs being administered to Patient X
3	**Blood transfusion**	Event in which RBC for Patient Y (type B) was erroneously brought into the operating theater for Patient X (type O) and administered to the patient
4	**Examination**	Event in which specimens became unidentifiable due to mislabeling when processing multiple urinary cytologic specimens

Fig. III-2-3 Overview of On-site Visits

Visit 2 **Event in which a patient mix-up when calling patients into the outpatient chemotherapy room resulted in Patient Y's anticancer drugs being administered to Patient X**

Event as reported

Summary of event	Background and causal factors	Improvement measures
Patient X was undergoing chemotherapy for intrahepatic cholangiocarcinoma. The patient X was due to receive her second course of chemotherapy in the form of Durvalumab with gemcitabine-cisplatin (50% CDDP) therapy in the outpatient chemotherapy room. On the day, Patient X had an outpatient consultation in the department of gastrointestinal medicine and underwent blood tests and an X-ray examination. After the nurse took Patient X's medical history in the outpatient chemotherapy room, Patient X was to have an outpatient consultation with a physician in the department of gastrointestinal medicine and then receive chemotherapy as planned. At 11:55, when Nurse A called the name of Patient Y, so that Patient Y could receive AC therapy for breast cancer, Patient X entered the room. Without asking Patient X to give her name or checking the patient's name against the basic outpatient slip, Nurse A assumed that Patient X was Patient Y, handed over Patient Y's basic outpatient slip, and showed Patient X to bed 20 in the chemotherapy room. The physician in charge of treatment and Nurse B assumed that Patient X in bed 20 was Patient Y and secured a peripheral venous route. When Nurse B read out Patient Y's full name while showing Patient X the label on the bottle of the anticancer drug, Patient X replied, "That's right," so they started the premedication. When subsequently changing the infusions, several nurses failed to have Patient X give her name in accordance with the manual. Although the nurses authenticated the infusions, they were unable to spot the error using the authentication process because there was no difference between the name on the basic outpatient slip and that on the infusion, and administration of the anticancer drug proceeded through to the end. When Patient Y subsequently complained about how long she had to wait, staff checked the situation and found that Patient Y's AC therapy drugs had been administered to Patient X.	• In the outpatient chemotherapy room, there was a certain period during which the patient was not in possession of her basic outpatient slip after completing reception procedures. • When calling the patient and checking her identity, the nurse did not carry out patient identification by having the patient give her full name and comparing it with the basic outpatient slip, in accordance with the manual. • When starting, changing, and finishing infusions, nurses failed to carry out patient identification by having the patient give her full name and comparing it with the basic outpatient slip.	• The medical institution will introduce wristbands for patients receiving treatment in the outpatient chemotherapy room. • After reception procedures are completed, the basic outpatient slip will be returned to the patient; nurses will then carry out patient identification in accordance with the manual when taking the patient's medical history, and will attach the patient's wristband. When subsequently calling the patient, nurses will have the patient give their name in accordance with the manual, and will check the patient name against both their wristband and basic outpatient slip before allowing them to enter the room. • Nurses will authenticate infusions before administering drugs. • The Nursing Department will continually audit patient identification and remind nurses to pay attention to it. • Aside from the outpatient chemotherapy room, the medical institution will also introduce wristbands in the central treatment room, endoscopy room, and health screening center.

Details of the On-site Visit

Attendees from the Medical Institution

Deputy Hospital Director; Deputy Nursing Director (in charge of outpatient care); nurse (Medical Safety Manager at the time of the event); nurse (Medical Safety Manager at the time of the visit); outpatient charge nurse

Findings

1. Lead-up to the event

[Lead-up to the administration of Patient Y's chemotherapy to Patient X]

11:55 Outpatient chemotherapy room General Lead Nurse A called the name of Patient Y, who was to receive AC therapy. When they did so, Patient X entered the outpatient chemotherapy room, but General Lead Nurse A showed Patient X to bed 20 where treatment was to take place, without having the patient herself give her name.

11:58 As the medical institution had a rule that physicians were to perform the venipuncture for the administration of vesicant drugs, Nurse B requested that a physician from the department of breast surgery perform the venipuncture. At the time of the venipuncture, Nurse B asked Patient X in bed 20 to give her name, but the patient did not reply. Accordingly, Nurse B read out Patient Y's name as printed on the label affixed to the bottle of normal saline while showing the label to Patient X and asked her to confirm it was right, whereupon Patient X replied, "That's right."

12:05 When Nurse B showed Patient X the label affixed to the premedication to be administered to Patient Y, Patient X replied, "That's correct," so Nurse B began administering the premedication. Subsequently, Nurse C compared the name on the label, and the infusion content, quantity, and duration with the injection order form, in order to carry out an asynchronous double-check, but did not check whether the patient in the bed was Patient Y.

12:19 When carrying out their round, Floor Lead Nurse D compared Patient Y's injection order form with the drugs being administered to check that there was no error.

12:38 When Nurse E showed Patient X the label bearing the name of Patient Y in order to replace the empty bottle with a bottle of normal saline, Patient X replied, "That's right," so Nurse E replaced the bottle.

12:42 When administering doxorubicin hydrochloride, Nurse E compared the injection order form with the label affixed to the infusion bottle. When Nurse E then called Patient X by Patient Y's name and showed her the label on the infusion, Patient X replied, "That's correct," so Nurse E began administering the infusion.

12:50 Floor Lead Nurse D carried out their round and visually compared Patient Y's injection order form with the names of the drugs being administered to check that there was no error in the drugs being administered.

13:00 Nurse F compared the Endoxan for Injection injection order form with the infusion label and then began administering the infusion.

13:25 When changing to normal saline, Nurse G showed Patient X the label affixed to the drug and said, "Ms. Y, isn't it?" Patient X replied, "That's correct," so Nurse G began administering the normal saline. As Patient Y's administration schedule stated that she was to be fitted with a G-Lasta Subcutaneous Injection BodyPod before returning home, Nurse G explained how to remove the needle.

13:30 Nurse E fitted the G-Lasta Subcutaneous Injection BodyPod to Patient X and explained the device again. The treatment was subsequently completed and Patient X returned home.

[Lead-up to the discovery of the fact that anticancer drugs had been administered to a different patient]

13:00 General Lead Nurse A called Patient X in to begin Patient X's treatment, but Patient X was not in the waiting corridor.

13:30 When staff telephoned Patient X's home, Patient X had not yet returned home.

14:00 When staff telephoned again, Patient X answered and said that she had returned home after receiving treatment. Patient X's medical record showed no evidence of her having been administered anticancer drugs.

14:30 Staff reported to the attending physician in the department of gastrointestinal medicine that Patient X had returned home without receiving treatment.

14:50 Patient Y went to the outpatient chemotherapy room reception desk and asked, "Isn't it time for my treatment yet?" When staff checked, the records showed that Patient Y's AC therapy had already been completed, and it was at this point that staff realized that Patient Y's anticancer drugs had been administered to Patient X. The physician subsequently decided to admit Patient X for observation.

2. Background and causal factors

○ Patient X

- Patient X was a woman in her 70s.
- Patient X and Patient Y did not have the same family name, nor was there any similarity in the kanji characters for or readings of their names.
- Patient X had been diagnosed with intrahepatic cholangiocarcinoma and had undergone her first course of chemotherapy in the form of Durvalumab with gemcitabine-cisplatin therapy as an inpatient the previous month.
- This was Patient X's second course of chemotherapy and was the first time that she was to receive treatment as an outpatient.
- There was information from Patient X's inpatient stay that she had hearing loss and lacked sufficient capacity to understand things. In addition, her physical condition on the day of treatment was poor.

- Durvalumab with gemcitabine-cisplatin therapy takes around 4 hours 20 minutes to complete, whereas AC therapy takes 1 hour 20 minutes, but Patient X did not realize that the treatment time was shorter than it had been on the previous occasion.
- While Patient X was receiving AC therapy in error, she noticed that she was receiving an infusion of a red drug solution that differed from what she had received as an inpatient, but she did not ask the nurse about it.
- After Patient X returned home, her husband saw that she was wearing a G-Lasta Subcutaneous Injection BodyPod and pointed it out to Patient X, saying that it was strange, because she had not had one when she was treated on the previous occasion.

○ Patient Y
- Patient Y was a woman in her 40s who had been diagnosed with breast cancer and was receiving AC therapy.
- Patient Y had used a G-Lasta Subcutaneous Injection BodyPod when she received AC therapy as an inpatient.
- Patient Y also was undergoing chemotherapy as an outpatient for the first time on this occasion.
- Patient Y was a nurse at another medical institution and understood that waiting times were long. However, she spoke to staff at the reception desk because she had been waiting for an excessively long time.
- Although the start of her treatment was delayed, Patient Y did begin to receive AC therapy at 16:00 on the day of the event.

○ Patient identification
- During outpatient consultations, patients are supposed to keep their basic outpatient slip with them, but in the outpatient chemotherapy room, patients have to hand over their basic outpatient slip, so there was no medium by which to identify the patient. Although the patient registration card had been returned to the patient, there was no practice of using patient registration cards as a medium for patient identification.
- The medical institution had established the following rule for patient identification: 1) have the patient give their full name; 2) medical personnel should compare the name given by the patient in step 1) with the name shown on the medical record, docket, or other documentation allowing the name to be checked (information at hand), then repeat the patient's name and check it with the patient.
- Several nurses were involved in treatment on this occasion, but none had the patient give her own name. While there were cases in which they asked the patient to give her name, when the patient failed to reply, they carried out patient identification by showing the patient the label on the infusion bottle. As patients had never previously been misidentified under normal circumstances, even when patients had failed to give their name, the nurses were unaware of the importance of following the established rule and the practice of having patients give their name had not become a habit.

○ Outpatient chemotherapy room
- There are 20 beds/reclining chairs for patients, with a computer cart installed at the foot of each, so that nurses can place their computer and any drugs to be administered on the cart.
- The treatment location (bed position) is determined with consideration for such matters as the patient's clinical condition and how many rounds of treatment they have received.
- Between 20 and 75 people receive outpatient chemotherapy in the room every day; although the day of the event was not especially busy, the 10:00 to 14:00 time slot was always busy.
- Patients receiving treatment hand over their basic outpatient slip at the outpatient chemotherapy room reception desk, then wait in the waiting corridor outside the outpatient chemotherapy room until they are called in by the nurse.
- On the day of the event, 14 patients due to be treated were waiting in the waiting corridor, with some accompanied by family members, so many people were sitting there.

○ Outpatient chemotherapy room nurses
- There are seven nurses, along with nurses who concurrently carry out ward duties. Usually, there are around 5.5 nurses working in the outpatient chemotherapy room.
- Because Patient X and Patient Y were both receiving chemotherapy as outpatients for the first time, the outpatient chemotherapy room nurses were not acquainted with them.
- Although there was an age difference of around 30 years between Patient X and Patient Y, the nurses did not notice this difference.
- The nurses were supposed to call patients based on the basic outpatient slips, then have the patient give their name and compare it with the name on the slip, but the nurse did not do so in this case.
- Patient X's infusion was changed five times while she was receiving treatment, but the four nurses involved did not carry out patient identification in accordance with the medical institution's rule, because they assumed that the patient in the bed was the correct one, Patient Y.
- The nurses failed to carry out the medical institution's established patient identification procedure amid a situation in which they were multitasking, carrying out such tasks as answering nurse calls from other patients receiving treatment, responding to alarms on infusion pumps, performing venipunctures, assisting patients who wanted to walk to the toilet, and distributing drugs dispensed by the pharmaceutical department.

○ Physician who performed the venipuncture
- The physician from the department of breast surgery (who had four years of professional experience and had been assigned to the department for one year) was Patient Y's attending physician.
- On the day of the event, the physician was called because they were on venipuncture duty and therefore was not aware that it related to the treatment of Patient Y, who was under their care.
- Because nurses were supposed to identify patients before they occupied a bed, there was a basic assumption that patient identification had been completed, and physicians therefore did not usually carry out patient identification when on venipuncture duty.

○ Drug processes in the outpatient chemotherapy room
- Drugs administered in the outpatient chemotherapy room are prepared by a pharmacist in the pharmaceutical department, which is adjacent to the outpatient chemotherapy room.
- There is basically one pharmacist in charge of preparing anticancer drugs, and the pharmacist has no duties that involve dealing with patients in the outpatient chemotherapy room.
- The pharmaceutical department and the outpatient chemotherapy room are adjacent to each other, separated by a wall, with the prepared drugs dispensed via a window.
- Nurses take drugs dispensed from the pharmaceutical department to each patient's bedside and compare them with the prescription before placing them in the basket on the computer cart.

3. Main improvement measures introduced after reporting the event
- The medical institution decided to have certain patients seen as outpatients wear wristbands, namely patients receiving chemotherapy as outpatients, patients undergoing procedures or blood transfusions in the central treatment room, patients undergoing invasive treatment or procedures (such as central venous port insertion or gastrostomy replacement) in the radiological examination room, and patients undergoing endoscopic treatment at the endoscopy center.
- The wristband system in the outpatient chemotherapy room operates as follows.
  1) The patient completes the reception procedure at the outpatient chemotherapy room reception window.
  2) The clerk prints out a wristband.
  3) The nurse who takes the patient's medical history has the patient give their name and date of birth, and compares these details with the information printed on the wristband.
  4) If there are no problems with the information in 3), the nurse puts the wristband on the patient's wrist.
- The medical institution has added matters including patient identification and the use of wristbands in the outpatient department to its adverse event prevention manual.
- In its in-house medical safety newsletter, the medical institution warned about continued instances of patient misidentification, and informed staff that they must have patients give their name, and then check this against another medium, such as a wristband or document of some kind.

Discussion during the visit, etc. (○: Visitor, ●: Attendees from the Medical Institution)

○ One understands that the medical institution had a rule about patient identification, but that it was not carried out in accordance with the rule. When medical personnel say, "You're Mr./Ms. So-and-so, aren't you?" patients sometimes answer in the affirmative, even if the name is wrong. It is also important to assess patients' cognitive skills and level of understanding, and deal with them accordingly. In addition, medical personnel must be aware that in patient identification, rather than merely having the patient give their name, it is vital to have the patient give their name and then to compare it with the information at hand.

○ One background issue was that the nurses were busy multitasking. Although merely being busy would not appear to be the root cause of patient misidentification, it is important to consider the factors contributing to the nurses being busy. Unless the root causes of multitasking are resolved, there is a possibility that nurses might end up becoming negligent about patient identification on the grounds that they are busy.

○ The medical institution to which the On-site Visitor belongs has identified which tasks can only be performed by nurses and altered the assignment of tasks accordingly. It might be possible to involve a pharmacist in dealing with patients receiving treatment, or there might be things that nursing assistants could do. Thinking about shifting tasks to other occupations would also seem to be an option.

● As a single pharmacist prepares the drugs for outpatient chemotherapy at present, it might be difficult to involve a pharmacist, but we intend to consider shifting tasks.

○ One wonders what the effects of introducing outpatient wristbands has been.

● We had already been considering the use of wristbands on outpatients, but this event was the catalyst for their successful introduction. It has tightened up the authentication process by providing three points of comparison, in the form of the wristband, the prescription, and the drug label, so we believe that it has lessened both the burden of the task itself and the psychological burden.

○ The medical institution stated that one measure taken to ensure that patients gave their full name was a warning about patient misidentification published in the medical safety newsletter. As time goes by, there is a tendency for staff in clinical settings to take short cuts and to stop abiding by procedures. After taking measures such as these, it is important also to check that staff are abiding by patient identification procedures. One wonders how you check this at your medical institution.

● Staff from the Medical Safety Management Office go around the outpatient department and wards to carry out checks to ensure that clinical staff are having patients give their names in patient identification settings. While some staff are following the procedure, there have been staff who have ended up saying patients' names without having patients give them themselves, so we intend to continue warning staff about this matter. As patient cooperation is also a key part of patient identification, we have put up signs in the outpatient department and other places where they will be highly visible, to tell patients that we will have them give their name for the purpose of patient identification.

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 77th to 80th Quarterly Reports, which covered the period under analysis for events reported in 2024.

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 Prescription Errors Around the Time of Discharge (2)	77th
[2] Events Related to Ward or Departmental Stock Drugs (1)	78th
[3] Events Related to Ward or Departmental Stock Drugs (2)	79th
[4] Events Related to Gastrostomy/Enterostomy and Associated Catheter Change/Management (1)	80th
[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 Delays to the Start of Treatment Based on Interpretation Results Despite the Diagnostic Imaging Report Being Marked "Read"	79th

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 77th to 80th Quarterly Reports, which analyzed events reported in 2024, 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. Fig. 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.
Events Related to the Transceivers of Wireless Electrocardiogram Monitors (38th Quarterly Report)	77th
Events Related to Wrongly Inserted Gastric Tube (43rd Quarterly Report)	
Specimen mix-up at pathological diagnosis (Medical Safety Information No.53)	78th
Burns Caused by a Pulse Oximeter Probe (Medical Safety Information No.161)	
Reactivation of Hepatitis B Due to Immunosuppression/Chemotherapy (Medical Safety Information No.171)	79th
Wrong Choice of Pneumococcal Vaccine Preparation (Medical Safety Information No.97)	80th
Events Related to Wrong-Site Procedures Due to Mix-ups between Left and Right During Examinations, Treatment and Other Procedures (55th Quarterly Report) —Left/Right Mix-up in Nerve Block Procedures—	

IV

Medical Safety Information

IV Medical Safety Information

1. Summary

Since December 2006, this project has been using information from reports as the basis for Medical Safety Information bulletins that provide information requiring particularly widespread circulation. To help prevent the occurrence/recurrence of medical adverse events, this information is made available to the general public via the website.

2. Medical Safety Information Released in 2024

Medical Safety Information bulletins No.206 to No.217 were issued between January and December 2024.

Fig. IV-2-1 Medical Safety Information released in 2024

Month of information supply	No.	Title
January	No.206	Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions (1st Follow-up Report)
February	No.207	Use of Blood Purifiers Contraindicated in Patients Receiving ACE Inhibitors
March	No.208	Medical Safety Information Released in 2023
April	No.209	Use of a Peripheral Vein to Administer an Infusion That Should Be Administered through a Central Vein
May	No.210	Blockage of Heat and Moisture Exchanger Due to Use in Combination with a Heated Humidifier
June	No.211	Medical Safety Information Highlighted in Quarterly Reports in 2023
July	No.212	Delayed Discovery of the Migration of an Open Drain into the Body
August	No.213	Error When Changing Syringe on Syringe Pump
September	No.214	Incorrect Handling of Open-System Three-Way Stopcock
October	No.215	Hypoglycemia Due to Insulin Administration When Patient's Meals Had Been Stopped
November	No.216	Ineffective Ventilation of a Patient with a Permanent Tracheostomy
December	No.217	Guidewire Breakage Due to Combined Use with a Metal Needle

V

Current Status of the Project

V Current Status of the Project

This chapter describes the project's achievements in 2024, 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 77th to 80th Quarterly Reports.

1. Dissemination of Information about the Project

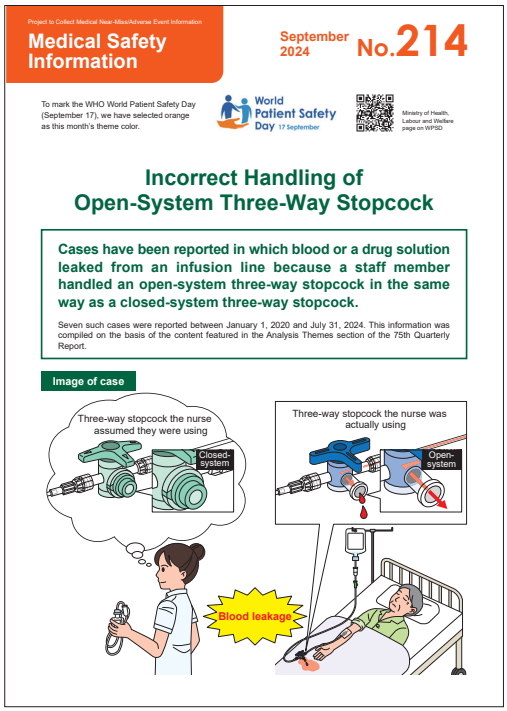
The project publishes Quarterly Reports, the Annual Report, and monthly Medical Safety Information bulletins, as well as providing a database of events and holding workshops. The pamphlet "Project Activities and How to Participate" (https://www.med-safe.jp/pdf/business_pamphlet.pdf) provides a user-friendly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

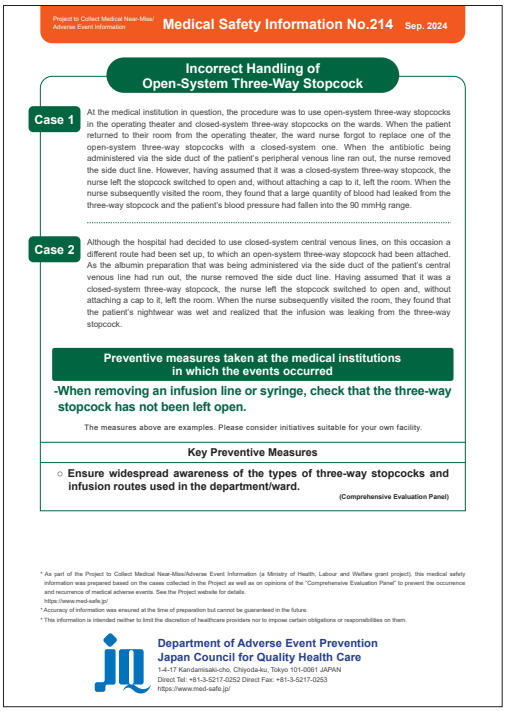
2. Provision of Medical Safety Information

1) 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 2024 was improving diagnosis for patient safety, and the slogan was "Get it right, make it safe!" 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. Since 2022, this project has marked the event by changing the background color of the September Medical Safety Information bulletin to orange. In 2024, Medical Safety Information No.214 was colored orange.

Fig. V-1 Medical Safety Information No.214 Using Orange as the Background Color (issued in September 2024)





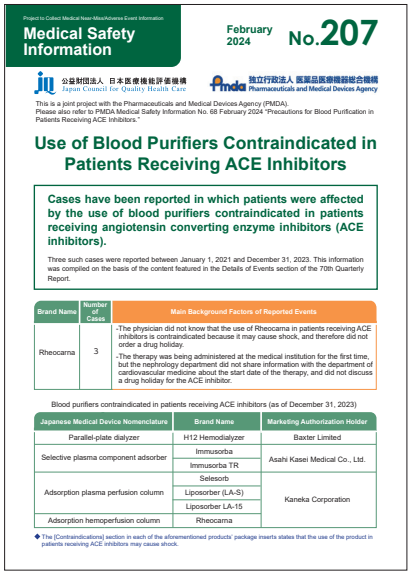
2) Medical Safety Information Issued as a Joint Project with the Pharmaceuticals and Medical Devices Agency (PMDA)

This project regularly exchanges information with the Pharmaceuticals and Medical Devices Agency (PMDA), which has led to the simultaneous issue of Medical Safety Information bulletins on a common theme as a joint project by the two initiatives.

In February 2024, we issued the joint project bulletin: Medical Safety Information No.207 “Use of Blood Purifiers Contraindicated in Patients Receiving ACE Inhibitors.” We then issued Medical Safety Information No.217 “Guidewire Breakage Due to Combined Use with a Metal Needle” in December 2024.

We plan to continue considering various themes in collaboration with the PMDA and issuing Medical Safety Information bulletins as a joint project. We hope that this information will continue to be of use in promoting medical safety.

Fig. V-2 Medical Safety Information No.207 and PMDA Medical Safety Information No.68 (Partial Extract)


Medical Safety Information

February 2024 No.207

Use of Blood Purifiers Contraindicated in Patients Receiving ACE Inhibitors

Cases have been reported in which patients were affected by the use of blood purifiers contraindicated in patients receiving angiotensin converting enzyme inhibitors (ACE inhibitors).

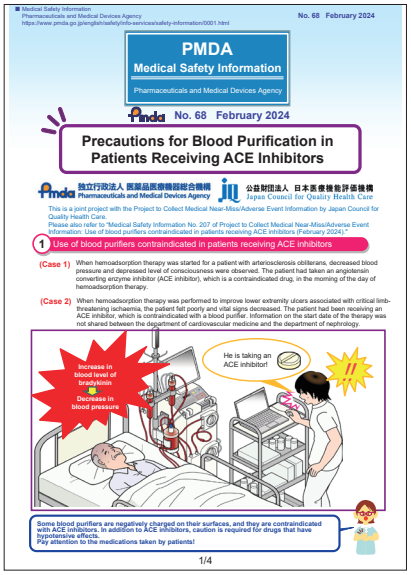
Three such cases were reported between January 1, 2021 and December 31, 2023. This information was compiled on the basis of the content featured in the Details of Events section of the 70th Quarterly Report.

Brand Name	Number of Cases	Main Background Factors of Reported Events
Rheocarna	3	-The physician did not know that the use of Rheocarna in patients receiving ACE inhibitors is contraindicated because it may cause shock, and therefore did not order a drug holiday. -The therapy was being administered at the medical institution for the first time, but the nephrology department did not share information with the department of cardiovascular medicine about the start date of the therapy, and did not discuss a drug holiday for the ACE inhibitor.

Blood purifiers contraindicated in patients receiving ACE inhibitors (as of December 31, 2023)

Japanese Medical Device Nomenclature	Brand Name	Marketing Authorization Holder
Parallel-plate dialyzer	H12 Hemodialyzer	Baxter Limited
Selective plasma component adsorber	Immusorba	Asahi Kasei Medical Co., Ltd.
	Immusorba TR	
Adsorption plasma perfusion column	Selesorb	Kaneka Corporation
	Liposorber (LA-S)	
	Liposorber LA-15	
Adsorption hemoperfusion column	Rheocarna	

◆The [Contraindications] section in each of the aforementioned products’ package inserts states that the use of the product in patients receiving ACE inhibitors may cause shock.


Medical Safety Information
Pharmaceuticals and Medical Devices Agency
No. 68 February 2024

PMDA
Medical Safety Information
Pharmaceuticals and Medical Devices Agency

No. 68 February 2024

Precautions for Blood Purification in Patients Receiving ACE Inhibitors

1 Use of blood purifiers contraindicated in patients receiving ACE inhibitors

(Case 1) When hemoadsorption therapy was started for a patient with arteriosclerosis obliterans, decreased blood pressure and depressed level of consciousness were observed. The patient had taken an angiotensin converting enzyme inhibitor (ACE inhibitor), which is a contraindicated drug, in the morning of the day of hemoadsorption therapy.

(Case 2) When hemoadsorption therapy was performed to improve lower extremity ulcers associated with critical limb-threatening ischaemia, the patient felt poorly and vital signs decreased. The patient had been receiving an ACE inhibitor, which is contraindicated with a blood purifier. Information on the start date of the therapy was not shared between the department of cardiovascular medicine and the department of nephrology.

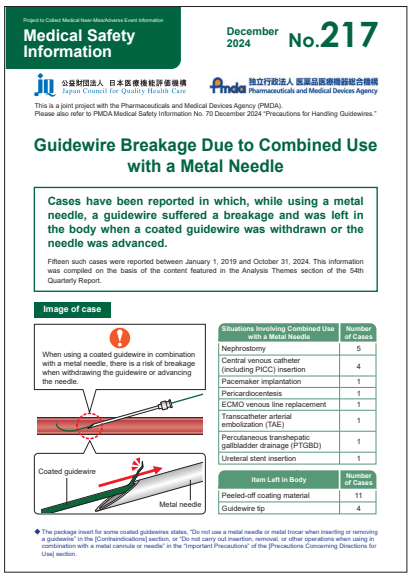
Increase in blood level of bradykinin → Decrease in blood pressure

He is taking an ACE inhibitor!

Some blood purifiers are negatively charged on their surfaces, and they are contraindicated with ACE inhibitors. In addition to ACE inhibitors, caution is required for drugs that have hypotensive effects. Pay attention to the medications taken by patients!

1/4

Fig. V-3 Medical Safety Information No.217 and PMDA Medical Safety Information No.70 (Partial Extract)


Medical Safety Information

December 2024 No.217

Guidewire Breakage Due to Combined Use with a Metal Needle

Cases have been reported in which, while using a metal needle, a guidewire suffered a breakage and was left in the body when a coated guidewire was withdrawn or the needle was advanced.

Fifteen such cases were reported between January 1, 2019 and October 31, 2024. This information was compiled on the basis of the content featured in the Analysis Themes section of the 54th Quarterly Report.

Image of case

When using a coated guidewire in combination with a metal needle, there is a risk of breakage when withdrawing the guidewire or advancing the needle.

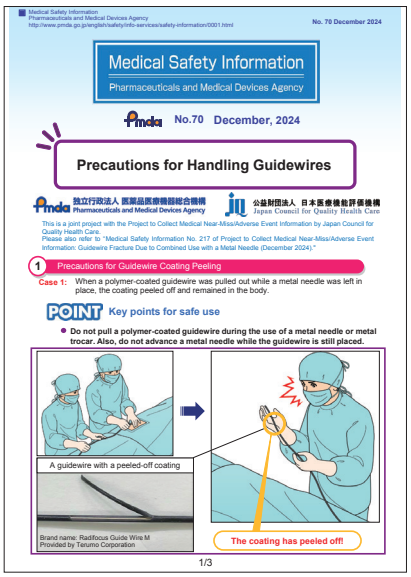
Coated guidewire

Metal needle

Situations Involving Combined Use with a Metal Needle	Number of Cases
Nephrostomy	5
Central venous catheter (including PICC) insertion	4
Pacemaker implantation	1
Pericardiocentesis	1
ECMO venous line replacement	1
Transcatheter arterial embolization (TAE)	1
Percutaneous transhepatic gallbladder drainage (PTGBD)	1
Ureteral stent insertion	1

Item Left in Body	Number of Cases
Peeled-off coating material	11
Guidewire tip	4

◆The package insert for some coated guidewires states, “Do not use a metal needle or metal trocar when inserting or removing a guidewire” in the [Contraindications] section, or “Do not carry out insertion, removal, or other operations when using in combination with a metal cannula or needle” in the “Important Precautions” of the [Precautions Concerning Directions for Use] section.


Medical Safety Information
Pharmaceuticals and Medical Devices Agency
No. 70 December 2024

Medical Safety Information
Pharmaceuticals and Medical Devices Agency

No.70 December, 2024

Precautions for Handling Guidewires

1 Precautions for Guidewire Coating Peeling

Case 1: When a polymer-coated guidewire was pulled out while a metal needle was left in place, the coating peeled off and remained in the body.

POINT Key points for safe use

● Do not pull a polymer-coated guidewire during the use of a metal needle or metal trocar. Also, do not advance a metal needle while the guidewire is still placed.

A guidewire with a peeled-off coating

Brand name: Radifocus Guide Wire M Provided by Terumo Corporation

The coating has peeled off!

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3. Publication of the English-language Editions of the 2023 Annual Report and Medical Safety Information No.204-215

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 2025, we published the English translation of this project's 2023 Annual Report, entitled "Project to Collect Medical Near-miss/Adverse Event Information 2023 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.204 to No.215 were published in March 2025 (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 March 2025

No.	Title in English
No.204	Misconnection of Inspiratory and Expiratory Sides of a Ventilator Circuit
No.205	Implantation of Another Patient's Intraocular Lens
No.206	Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions (1st Follow-up Report)
No.207	Use of Blood Purifiers Contraindicated in Patients Receiving ACE Inhibitors
No.208	Medical Safety Information Released in 2023
No.209	Use of a Peripheral Vein to Administer an Infusion That Should Be Administered through a Central Vein
No.210	Blockage of Heat and Moisture Exchanger Due to Use in Combination with a Heated Humidifier
No.211	Medical Safety Information Highlighted in Quarterly Reports in 2023
No.212	Delayed Discovery of the Migration of an Open Drain into the Body
No.213	Error When Changing Syringe on Syringe Pump
No.214	Incorrect Handling of Open-System Three-Way Stopcock
No.215	Hypoglycemia Due to Insulin Administration When Patient's Meals Had Been Stopped

4. Workshops

The project holds workshops for registered medical institutions to inform them about the current status of the project and encourage high-quality reporting. In FY2024, we held the Workshop on Process Flows took place on Saturday, February 8, 2025 .

5. Questionnaire Concerning the Project

As this project marked its 20th anniversary in September 2024, we conducted a questionnaire-based survey among medical institutions participating in the project. Our goal in doing so was to ascertain the extent to which participating medical institutions make use of the information published as part of the project, including Medical Safety Information, quarterly and annual reports, and the event search section of the website.

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-5 shows the international conferences covered in quarterly reports Published in 2024. Details of the specific topics covered at each conference can be found in the Quarterly Report in which it was covered.

Fig. V-5 International Conferences, etc. Covered in Quarterly Reports Published in 2024

Quarterly Report No.	Conference, etc.	Schedule	Location, etc.
77th	Interview by the Institute of Global Health Innovation, Imperial College London (ICL)	August 21, 2023	–
	G20 Health Ministers' Meeting	August 18-19, 2023	Republic of India
	39th ISQua Conference	August 27-30, 2023	Swiss Confederation
78th	WHO World Patient Safety Day 2023 Global Conference "Engaging patients for patient safety"	September 12-13, 2023	Republic of Korea
79th	Event to mark ASQua World Patient Safety Day 2023	September 26, 2023	–
	HSIB Conference 2023	September 27, 2023	United Kingdom of Great Britain and Northern Ireland
	ERNST (The European Researchers' Network Working on Second Victims) Forum	October 2, 2023	–
	WHO PS Education Training Network with Imperial College London (ICL)	October 17, 2023	–
	2nd G20 Global Patient Safety Leaders Group (GPSLG)	October 24, 2023	Kingdom of Saudi Arabia (online)
	HSSIB International Patient Safety Organisations Network (IPSON) Meeting	October 26, 2023	United Kingdom of Great Britain and Northern Ireland (online)
	Taichung Veterans Hospital International Conference on Quality Indicator (QI)	October 29, 2023	Taiwan (online)
	World Patient Alliance (WPA) Regional Meeting	November 4-5, 2023	United Arab Emirates

Quarterly Report No.	Conference, etc.	Schedule	Location, etc.
80th	Reception to mark the launch of the Global State of Patient Safety report by the ICL Institute for Global Innovation	December 11, 2023	United Kingdom of Great Britain and Northern Ireland
	Annual Conference of Hospital Management (ACHOM) 2023	November 9, 2023	Republic of Indonesia
	Knowledge Sharing KARS, organized by KARS, Indonesia	January 19, 2024	Republic of Indonesia (online)
	HSSIB International Patient Safety Organisations Network (IPSON) Meeting	January 31, 2024	United Kingdom of Great Britain and Northern Ireland (online)
	HSSIB Consultation Meeting	February 28, 2024	United Kingdom of Great Britain and Northern Ireland (online)
	24th HA National Forum Thailand	March 14, 2024	Kingdom of Thailand
	CAHOCON 2024	April 5-7, 2024	Republic of India
	6th Global Ministerial Summit on Patient Safety	April 17-18, 2024	Republic of Chile

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Project to Collect Medical Near-miss/Adverse Event Information

2024 Annual Report

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