

## 297: Gaps in patient safety culture change by profession: Observations of an incident reporting system at a national university hospital in Japan

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### Objective:

To explore differences in the changes in patient safety culture between physicians and nurses, and to improve the quality of health care and patient safety management, by examining data gathered by the incident reporting system at Kyoto University hospital.

### Methods:

Kyoto University Hospital's incident reporting system was adopted in March 2000, just after the occurrence of a serious medical accident. We used 6,457 incident reports that were collected between April 2000 and December 2003.

### Results:

**Table 1. Trends in the number of incident reports by three-month period by profession**

FY Month	Doctors				Nurses			
	2000	2001	2002	2003	2000	2001	2002	2003
4-6	12	32	61	60	47	261	605	755
7-9	27	32	50	34	43	241	631	562
10-12	11	35	45	33	36	341	426	491
1-3	36	54	30		136	454	509	
Total	86	153	186	127	262	1297	2171	1808

The value was calculated by summing the number of incident reports over three months.

The number of incident reports filed by Doctors changed little after the initiation of the reporting system. The number of incident reports filed by Nurses increased gradually, especially after April 2001.

**Table 2. Departments where doctors made more incident reports, in ranked order**

Fiscal Year Department	2002			2003			Total number of reports (ranking)
	No. of reports (ranking)	No. of beds	No. of reports per 100 beds [ranking]	No. of reports (ranking)	No. of beds	No. of reports per 100 beds [ranking]	
A	39 (1)	38	102.6 [1]	22 (1)	38	57.9 [1]	61 (1)
B	14 (2)	41	34.1 [2]	7 (5)	32	21.9 [5]	21 (2)
C	10 (3)	31	32.3 [4]	7 (5)	29	24.1 [4]	17 (3)
D	8 (4)	24	33.3 [3]	6 (7)	24	25.0 [2]	14 (7)
E	8 (4)	41.5	19.3 [5]	3 (14)	42.5	7.1 [13]	11 (10)

Department A filed the most reports because the serious accident occurred there.

**Table 3. Inpatient wards where nurses made more incident reports, in ranked order**

Fiscal Year Inpatient Ward	No. of beds	2002		2003		total	
		No. of reports (ranking)	No. of reports per bed [ranking]	No. of reports (ranking)	No. of reports per bed [ranking]	Total number of reports (ranking)	No. of reports per bed (ranking)
a	66	261 (1)	3.95 [1]	121 (2)	1.83 [3]	382 (1)	5.79 [1]
b	64	208 (2)	3.25 [2]	118 (3)	1.84 [2]	326 (2)	5.09 [2]
c	67	181 (3)	2.70 [3]	83 (6)	1.24 [4]	264 (4)	3.94 [4]
d	65	138 (4)	2.12 [4]	60 (10)	0.92 [5]	198 (5)	3.05 [5]
e	65	134 (5)	2.06 [5]	180 (1)	2.77 [1]	314 (3)	4.83 [3]

In wards C and D, the number of reports decreased, but the number in E ward increased after the hiring of new chief nursing staff in April 2003.

### Conclusions:

Though development of patient safety culture is already officially mandated, to ensure patient safety and to improve the quality of health care in hospitals, the following issues must be addressed:

- It is very important to motivate doctors to be attentive to patient safety.
- Each department and ward requires a director or a chief nurse who is the champion of patient safety.