

## **250: SHARING ADVERSE EVENT INFORMATION AMONG ACCREDITED HOSPITALS FOR PATIENT SAFETY IN JAPAN COUNCIL FOR QUALITY HEALTH CARE**

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### **Objective:**

The purpose of this project is to share experiences of the adverse events in accredited hospitals by collecting, analyzing and feeding back the data for prevention of medical accidents and errors.

### **Methods:**

JCQHC (Japan Council for Quality Health Care) organized a conference for patient safety composed of 48 accredited hospitals in Oct. 2001. (Hospital accreditation in Japan started in 1997, voluntarily applied, with standard-based method by JCQHC. In June 2003, the accumulated number of hospitals applying the survey is 1664, among them about 1100 hospitals finished the survey, 838 hospitals were accredited and about 500 hospitals are waiting for the survey).

The conference reached the agreement that a member hospital should make effort to offer information related to adverse event to JCQHC according to two types of format. One is a proposal for patient safety based on experiences in each hospital, and the other is an actual case report of adverse event happened in the hospital recently. Each format includes such items as; type of adverse event, progress of the event, causes and backgrounds of the event, measures or policies taken, the effectiveness for prevention, and so on.

Documents with FD from the hospital were sent to JCQHC by registered mail and the data have been kept safely in the stand-alone data-base system. When the cases are discussed in the conference, anonymousness of the data shall be considered with maximum effort.

The conference, actually several sectional meetings or workshops have been held periodically and the proposals and the case reports have been discussed. Outline of the discussion and the results are returned to each hospital through participants and the journal published quarterly. The special subcommittee composed of core members of the conference has been functioning for planning and steering the activity of the conference.

### **Results:**

In November 2002, after almost one year activity of the conference, 135 proposals for patient safety and 43 case reports including severe adverse events have been offered from the member hospitals, and offering of the information is still continued. Actually, distinction between the proposal and the case report is not clear, so the proposals include severe and suggestive cases.

During these 16 months, the conference held more than 10 meetings including the special committee, and the result of the discussions has been edited and published as the Journal for Patient Safety. Contents of the first issue are as follows;

1. Standardization of ordering insulin injection; focused on handling sliding scale
2. Sharing protocols of anticancer drugs
3. Prevention of patient misconception
4. Prevention of embolism in peri-operative stage
5. Detailed case reports:
  - 1) Over-dose medication on computer ordering
  - 2) Post-operative complication induced by wrong pathological diagnosis

In Japan, such kinds of activities as offering adverse event information including medical error out of the hospital voluntarily, and many hospitals discuss urgent problems themselves, are the first trial. Although the offering information on medical error out of the hospital has a difficult problem on legal evidence, member hospitals wish to continue activities of the conference for patient safety.

### **Conclusions:**

Sharing adverse event information and experiences among accredited hospitals proved to be fairly effective to motivate hospitals and staffs to cope with patient safety. These activities have been funded by Ministry of Health, Labour and Welfare as a feasibility study.

Based on these results, from Apr. 2003, the activity of the conference for patient safety is to be one of the formal projects of JCQHC. Any accredited hospital could join the conference for patient safety, and the number of member hospitals is expected to be more than several hundreds.