Practices in Hospital Quality Management and Patient Safety in Vietnam: Challenges and Achievements

Based on Proceedings and Discussions in the 1st Vietnam Forum on Quality Management and Patient Safety, Hanoi, Vietnam in January 19-21, 2016

Volume 1

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Foreword

Healthcare is application of medicine into society[1]. To tackle quality in healthcare, it is essential to discuss “What are requirements of quality in healthcare in a society?”. Then there comes another question: “Can an international cooperation project led by an outsider help generate such discussion in one country and its localities?" This has been the theme challenged in the project of “Strengthening Management Capability for Quality and Safety in Healthcare” by National Center for Global Health and Medicine, Japan for three years from 2015 to 2017.

Similar to other international cooperation projects, the project conducted trainings on quality and safety in healthcare in Japan. The Project invited a total of 26 heads or vice heads of quality management departments in 25 hospitals in Vietnam, one person from UNICEF and two people from Ministry of Health, Vietnam. However, we can imagine such trainings alone will only encourage individual hospitals to strengthen their practices of quality and safety in healthcare. Therefore, the project created an opportunity for those who actually work on Hospital Quality Management and Patient Safety (HQM/PS) to share practical experiences and to discuss application of practices of HQM/PS. That was “Vietnam Forum on Hospital Quality Management and Patient Safety”. It was an opportunity for graduates and others who are in charge of HQM/PS to learn about practical experiences in other hospitals and to seek for better approaches that are applicable in Vietnamese context.

In Vietnam, efforts and progress of HQM/PS still differ in different hospitals. If hospitals with slow progress knew practical experiences in hospitals with rapid progress, it would provide hints for them to progress faster. If certain approaches need more discussion on how to apply them into hospitals in Vietnam, participants from several hospitals could discuss it based on their practical experiences. We believe such wave of sharing and discussion among people who are in charge of HQM/PS would contribute to significant advance in HQM/PS in Vietnam.

Finally, as development partners, do we really know what efforts on HQM/PS are going on in hospitals in Vietnam? As members of the project team, two editors of this book had several opportunities to observe hospitals in Vietnam, to meet people in charge of HQM/PS, and to conduct trainings and to support Vietnam Forum on HQM/PS. However, when we study the forum’s discussion, we still learned more about how wide and how deep application of practices on HQM/PS were discussed among practitioners in Vietnam.

So the research project “Visualization of progress of efforts on quality and safety in healthcare in developing countries (27 Shitei 2)” made an English book by compiling and editing abstracts and presentations in the Vietnam Forum on Hospital Quality Management and Patient Safety. We hope this book will help development partners to know more about ongoing efforts in hospitals in Vietnam. When we know efforts and difficulties in hospitals in Vietnam, we believe we could discuss and offer better international cooperation in the field of Hospital Quality Management and Patient Safety.

The research team of Visualization of progress of efforts on quality and safety in healthcare in developing countries

1. All Japan Hospital Association (AJHA) 2016 What hospitals ought to be - Report of the Committee on the Future of Hospitals 2015-2016 http://www.ajha.or.jp/voice/arikata/2016/02.html, Access: 16 March, 2017

Abbreviation

AMS	Antimicrobial stewardship
CQI	Continuous quality improvement
DI	Diagnostic imaging
DOH	Department of Health
EBM	Evidence-based medicine
ESBL	Extended-spectrum beta-lactamase
FE	Functional examination
GPD	General planning department
HQS	Hospital Quality Standards
ICU	Intensive care unit
IRS	Incident reporting system
KYT	Hazard prediction training (Kiken yochi training)
MOH	Ministry of Health
NAP	National Action Program
OPD	Outpatient department
PDCA	Plan – Do – Check - Act
PS	Patient safety
QI	Quality improvement
QM	Quality management
QMD	Quality management department
RCA	Root cause analysis
SOP	Standard operational procedure
SSI	Surgical site infection
VAP	Ventilator associated pneumonia

Session 1

Challenges in Shifting from Punishment Culture to Learning Culture to Improve Patient Safety

Le Viet Nho, Nguyen Thi Thach Cam, Phan Thi Thu Thuy

Quality Management Department, Quang Nam Central General Hospital

1. Reason for choosing the topic

Safety culture, the core of which is building up a culture of learning from errors, encourages staff to voluntarily report medical incidents. On the contrary, punishment culture makes staff hide incidents because they are afraid that their prestige would be affected and especially afraid of being blamed or punished, which does not help create an environment for learning, especially learning from mistakes. Punishment culture has rooted in many hospitals, including Quang Nam Central General Hospital. Therefore, shifting from punishment culture to learning culture faces many challenges. The most visible manifestation is that medical incidents are not reported, analyzed and responded sufficiently and properly. Therefore, we expect to find these real challenges to develop feasible and effective solutions to shift from punishment culture to learning culture to improve patient safety (PS).

2. Implementation plan

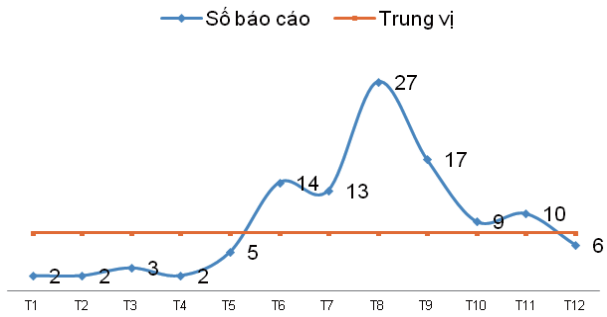
- Studying the results of incident collection, handling and response of the voluntary incident reporting system (IRS) as well as the alternate incident detection system of the Quality Management Department (QMD).

- Surveying staff perception on safety culture in the hospital in two rounds: the first in April 2015 and the second in October 2015.

3-a. Current state

- Results of the voluntary IRS's incident collection, handling and response as well as QMD's alternate incident detection system show that:

After establishing the IRS, the number of medical incident reports increases with an average of 7.5 reports per month, but the data is not stable: the number of reports gradually increases from April to the peak in August, then decreases gradually, the difference between months can reach more than 200% (Figure 1):



05 incidents at level 3b or above were not reported.

- Actual state of incident collection, analysis and response shows that:

Only some incidents at level 3b were root cause analyzed, providing report and feedback to the system.

- Results of safety culture surveys in April and October 2015:

Regarding the question "In the hospital, medical incidents are handled properly", the rate of "agree" and "strongly agree" reduces from 77.9% (first round) to 64.3% (second round); the rate of "neither agree nor disagree" increases from 19.1% to 26.1%; the rate of "disagree" and "strongly disagree" increases from 3.1% to 9.7%.

3-b. Objectives

- The average number of incident reports is 10 reports/ month, with difference within 100%. All reports are analyzed and feedback is given to all staff properly. Reports of incidents at level 3 or above are root cause

analyzed.

- Hospital culture changes positively, with the rates of staff agree that "medical incidents are handled properly" increase to more than 80%.

4. Analysis of the affecting factors

Causes of punishment culture come from 2 groups:

4.1. Objective causes: Difficult to change

Society: Community still blame individuals for making mistakes; most people expect to specify who is responsible for errors that happen.

Legal system and policy:

- Incomplete legal system in terms of protection of people who report incidents.

- Policy contradiction is an obstacle for institutions to change their culture through staff training, especially health insurance payment policy.

- There are no mechanisms for protection and safety assurance for reporters when reporting errors.

- There are no independent agencies responsible for monitoring medical incidents.

4.2. Subjective causes: Can be changed

The hospital has not developed a safe environment for reporting or displaying medical incidents:

- The top leaders of hospital and departments are not yet committed and don't regularly confirm non-punishment policy for incident reporting.

- Hospital policies are not consistent and do not show priority for PS.

- Healthcare workers, especially doctors, are not believing in the organization and effectiveness of IRS.

QMD and in-charge staff lack experience in collecting and analyzing medical incidents and giving feedback to hospital staff properly:

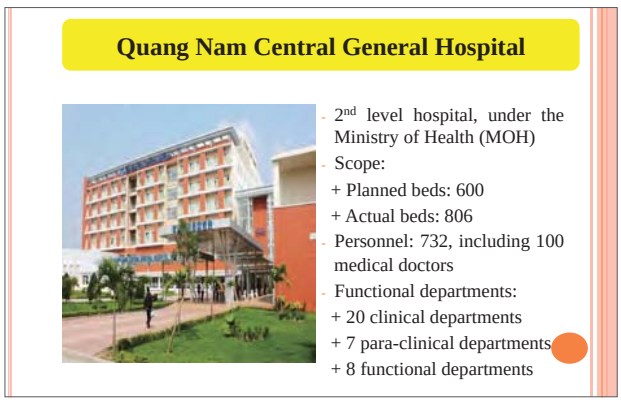
- In-charge staff and PS network haven't been trained and organized for proper operation.

- Procedures for receiving, collecting and analyzing incidents and giving feedback are not complete yet.

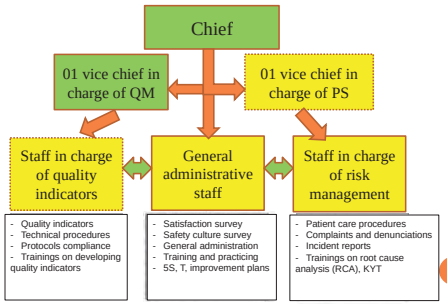
Actual state of PS training for hospital leaders and staff:

- The number of leaders and doctors who were trained on PS is small: 8/11 members of QM Council, which is 73%; 17/38 doctors who are chiefs or vice chiefs of departments, 45%; 4/54 other doctors, 7%; 19/19 head nurses, 100%; 35/35 members of QM network, 100%.

- Training and communication activities are not maintained regularly and effectively.



Quality Management Department



Participation in PS training

Training and information sharing

QM network's monthly meeting

Major activities

- Focal point for development, implementation, monitoring and evaluation of QM activities according to MOH's Hospital Quality Standards (HQS) and internal evaluation
- As a permanent member of QM Council, monitoring and encouraging departments and units to implement quality improvement (QI) plans
- Conducting safety culture survey and satisfaction survey

1. REASON FOR CHOOSING THE TOPIC

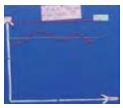
Learning culture **Punishment culture**

Major activities

Receiving and handling medical incidents

Developing and measuring quality indicators

RCA



Quality indicators

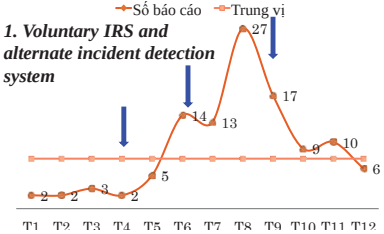
Support departments to develop PDCA improvement plans

2. ACTION PLAN

1. Studying the results of incident collection, handling and response of the voluntary IRS as well as the alternate incident detection system of the QMD.
2. Surveying staff perception on safety culture in the hospital in two rounds:
   - Round 1: April 2015
   - Round 2: October 2015

3. Actual state of the hospital

1. Voluntary IRS and alternate incident detection system



Monthly average number of incident reports: 7.5 reports
05 incidents at level 3b or above were not reported.
Only some incidents at level 3b were root cause analyzed, providing report and feedback to the system.

3. Actual state of the hospital

2. Results of safety culture surveys in April and October 2015
Regarding the question "In the hospital, medical incidents are handled properly"

- ❑ The rate of "agree" and "strongly agree" reduces from 77.9% (first round) to 64.3% (second round);
- ❑ The rate of "neither agree nor disagree" increases from 19.1% to 26.1%;
- ❑ The rate of "disagree" and "strongly disagree" increases from 3.1% to 9.7%.

Individual

- Conservative
- Do not accept change

Afraid to create conflicts and harm colleagues' prestige.
Not believing in benefits of change.

Objectives

- ❑ The average number of incident reports is 10 reports/ month, with difference within 100%. All reports are analyzed and feedback is given to all staff properly.
- ❑ 100% reports of incidents at level 3 or above are root cause analyzed.
- ❑ Hospital culture changes positively, with the rates of staff agree that "medical incidents are handled properly" increase to more than 80%.

ACTUAL STATE OF PS TRAINING FOR HOSPITAL LEADERS AND STAFF IS LIMITED:

- ❑ 45% of chiefs and vice chiefs of departments (17/38 doctors);
- ❑ 7% of other doctors (4/54 doctors);
- ❑ 100% head nurses (19/19 nurses);
- ❑ 100% QM network (35/35 members).
- ❑ 73% QM Council (8/11 members);

- Leaders of all levels are not yet understanding and believing, hesitant to change, not enthusiastic and impatient.
- Time consuming

Society's viewpoint

- Community
- Media
- Politicians, policy makers
- Hospital colleagues

Still blame individuals for making mistakes, that someone must be responsible for an incident that happens.

Causes

- ❑ Cultural aspect: Punishment culture has rooted in many organizations and individuals, that errors are individual mistakes and someone must be responsible for incidents that happen.
- ❑ **Roots causes:** Leaders of hospital and departments are not concerned and do not have effective solutions for developing a culture of learning from errors.

Solutions

- Hospital leaders commit with developing safety culture in the hospital (culture of learning from errors)
- Do not punish and make individual to take responsibility.

Step 1: Making plan

- Issuing "no punishment" policy for unintentional mistakes.
- Requesting commitment for involvement of leaders at all level and ensuring equity in implementing "no punishment" policy.
- Issuing confidential policy and reward policy for people who provide information on medical incidents.

Step 2. Training and communication

- Releasing "no punishment" policy to make all hospital staff understand, feel secure and voluntary to share their mistakes.
- Inviting experts to provide trainings on PS for doctors and nurses.
- Organizing contests on PS, medical incident situations.

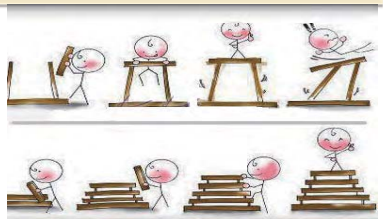
3. Compliance and implementation

- Monitoring and comparing numbers of mandatory and voluntary incident reports.
- Timely handling reported incidents and identifying lessons learnt from mistakes.

4. Evaluation of implementation

- The monthly average number of incident reports
- The ratio of voluntary incident reports/mandatory incident reports
- The rate of incidents that are analyzed and responded out of the total monthly incident reports
- Survey on staff perception on safety culture in the hospital.
- Evaluating achieved results and providing solutions for improvement or maintaining.

"To err is human, to cover up is unforgivable, and to fail to learn is inexcusable."
Liam Donaldson



Session 2-1

Establishment of Medical Incident Management System in Bach Mai Hospital

Nguyen Thi Huong Giang, Nguyen Quoc Thai, Doan Ngoc Khanh
Quality Management Department, Bach Mai Hospital

1. Reason for choosing the topic

In regard to PS, recording medical incidents will help hospitals to analyze roots causes and generate preventive measures.

2. Implementation plan

- Establishing medical incident management system in all departments in the hospital, including detecting, reporting, analyzing incidents and giving feedback to help departments avoid repetition of past incidents.

3-a. Actual state

- In 2013, the hospital developed ISO procedure for "*Handling technical incidents*" to provide guidance for handling technical incidents and recording the reporter's information and the incident's severity in "*Technical Incident Reporting Notebook*" to identify responsible individuals. After three years of implementation, the number of incidents recorded in the notebook was very small and near misses were hardly recorded.

3-b. Objective

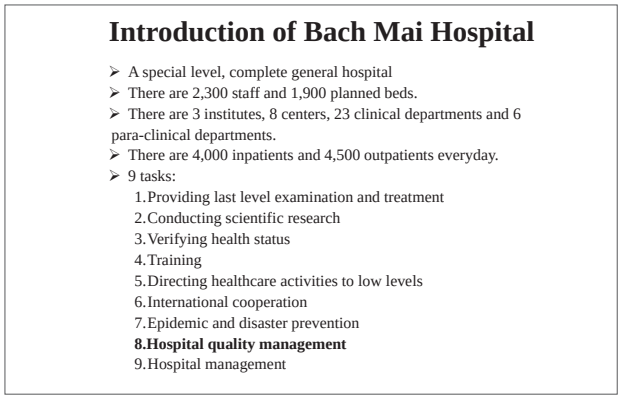
To establish a medical incident management system in Bach Mai Hospital.

4. Cause analysis

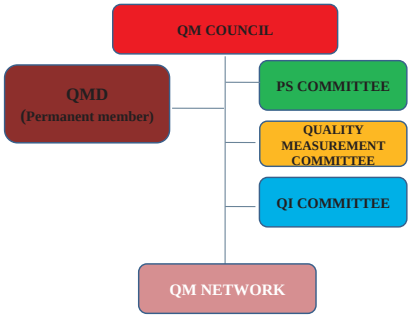
The previous system could not receive much information because incident report was accompanied with identifying who was responsible. Recognizing this issue, the new system is established to record unsafe events, no matter who commit mistakes. Then RCA will be conducted to generate preventive solutions.

5. Action plan

QMD develops an incident reporting form and guidelines for how to fill and send report, analyze root causes and giving feedback. The form and the guidelines will be sent to departments, especially members of QM network and QM Council, for comments. After releasing and two months of implementation, QMD will evaluate and consider adjustment if necessary.

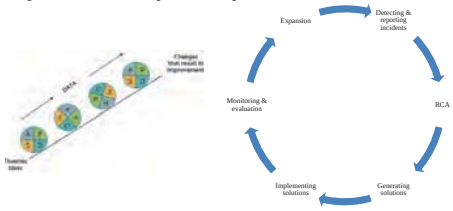


Organization of hospital QM system

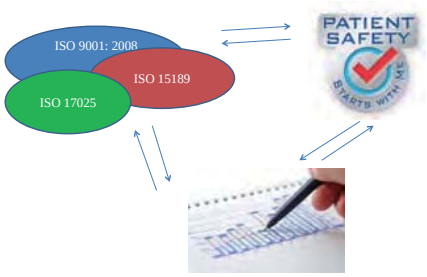


Action plan

Establishing medical incident management system in all departments in the hospital, including detecting, reporting, analyzing incidents and giving feedback to help departments avoid repetition of past incidents.



QM ACTIVITIES



Actual situation

In 2013, the hospital developed ISO procedure for "*Handling technical incidents*" to provide guidance for handling technical incidents and recording the reporter's information and the incident's severity in "*Technical Incident Reporting Notebook*" to identify responsible individuals. After three years of implementation, the number of incidents recorded in the notebook was very small and near misses were hardly recorded.

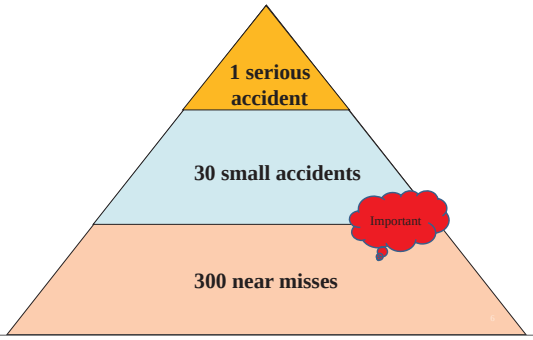
Reason for choosing the activity

In regard to PS, recording medical incidents will help hospitals to analyze roots causes and generate preventive measures.

Objective

TO ESTABLISH A MEDICAL INCIDENT MANAGEMENT SYSTEM IN BACH MAI HOSPITAL

Heinrich PRINCIPLE



Implementation plan

No.	Activities	Deadlines
1 2	Reviewing the old procedure to find inappropriate points Reviewing literature and experience of domestic and foreign hospitals	
3	Developing procedure and regulation for incident management	15/12/2015
4	Organizing QM network's meetings for comments	
5	QM Council approves	

Cause analysis

- Focus on serious incidents (following definitions of technical incident)
- The procedure focused on handling incidents. Serious incidents are handled at hospital level.
- There was no data collection and analysis in department and hospital levels.
- Near misses were not mentioned.
- Recording focused on information such as people who commits mistake, who reports, who witnesses…

DEVELOPMENT OF REGULATION ON INCIDENT MANAGEMENT

- Change definition of medical incident.
- Clearly specify in the regulation that "not aiming to punish any individual"
- Emphasize the "right" and "responsibility" of healthcare workers to report incidents.
- Encourage to report "unsafe situation"
- Can report anonymously
- Incident management procedure: receiving, analyzing, giving feedback, proposing QI activities, monitoring, evaluation...
- Collect and analyze data, give feedback to relevant departments and report to hospital leaders
- Include confidentiality

QMD MEETING

IMPLEMENTATION PLAN

No.	Activities	Deadlines
6	Hospital director issues regulation	31/12/2015
7	Training for QM network members	
8	Implementation (in some pilot departments)	15/1/2016
9	Evaluation after 2 months	3/2016
10	Adjust inappropriate points	

QM NETWORK MEETING

DIFFICULTIES AND CHALLENGES

- Encourage departments to report incidents
- Collecting information related to the incident is very important.
- Collaboration among relevant departments to analyze roots causes and to develop QI plans.
- Support from the MOH…

QM COUNCIL MEETING

Thank you for your attention!

Session 2-2

Developing Incident Reporting System in Ha Nam Provincial General Hospital

Phan Anh Phong

Vice Director, Ha Nam Provincial General Hospital

1. Reason for choosing the topic

IRS helps to control medical incidents that occur in hospitals: level, quantity, proportion, frequency, causes... thereby warnings and solutions will be provided to minimize potential incidents.

2. Action plan

1. Providing information and training about the benefits of reporting incident to all hospital staff;
2. Designing reporting form, completing procedures for reporting and handling reports;
3. Establishing the reporting system;
4. Implementation

3-a. Current state

1. Benefits of incident reporting were trained to all hospital's core members: the directing board, chiefs and vice chiefs of departments, head nurses (1/6 hospital manpower).
2. Reporting form and procedures for reporting and handling reports were designed.
3. An IRS was established in the hospital.
4. Implementation: Very few incident reports, mainly mandatory reports, voluntary reports are rare.

3-b. Objective

- 1-2 incident reports are received every day.

- Hospital incident book is published.

4. Cause analysis

- Not all hospital staff received trainings and guidance.

- Staff did not report voluntarily, did not understand the benefits of reporting and were afraid of punishment.

- The focal points of the system did not work actively.

- Personnel changes in the directing board.

5. Proposed solutions and actual implementation

- The directing board and core staff were provided information. However, only few people have changed their perceptions.

- IRS and procedure were developed. However, it does not function as well as expected.

6. Effectiveness and solutions

- Only some mandatory reports have been received, therefore it needs to reinforce information sharing and training, assign a staff to be in charge of incident report management, encourage focal people to work more actively, analyze root causes of reported incidents, protect reporters, and generate warnings so that people see the benefits of reporting.

7. Solutions to maintain and develp the system

- Make the director pay more attention.

- Assign an in-charge staff.

- Encourage focal people to work more actively

- Actively provide information and trainings and show effectiveness.

8. Lessons learned

- Establishing an IRS is not difficult.

- Making the system work effectively and bring real benefits is not simple.

Developing incident reporting system in Ha Nam Provincial General Hospital

Dr. Phan Anh Phong, MD., MSc.

Vice Director, Ha Nam Provincial General Hospital

TIMELINE

Activities	22/6	23/6	30/6	15/7	16/7	30/9	In charge
Meeting for implementation	→						Dr. Phong, QMD, Nursing Department
Studying manpower organization		→					Personnel Department, QMD
Developing reporting form		→		→			QMD, Nursing Department, Dr. Phong
Developing template incident management book		→		→			QMD, Dr. Phong
Network meeting Guide to report writing Finalize how to collect reports Finalize how to do analysis					→		Dr. Phong, QMD, Nursing Department
Training for all staff Why reporting incidents How to write report How to send report					→	→	QMD, Nursing Department, Training Department
Implementation					→	→	QMD

REASONS FOR CHOOSING THE TOPIC

"To err is human."

Previous state in Ha Nam Provincial General Hospital:

- Many medical incidents and errors used to occur and repeat in the hospital.
- Some incidents were hidden.
- Individuals who committed mistakes had to suffer all consequences.

Changes of perception after the training in NCGM

- IRS helps hospitals to control medical incidents: level, quantity, proportion, frequency, causes... thereby warnings and solutions will be provided to minimize potential incidents.

MEETING FOR PLAN IMPLEMENTATION

INCIDENT MANAGEMENT BOOK

PS NETWORK

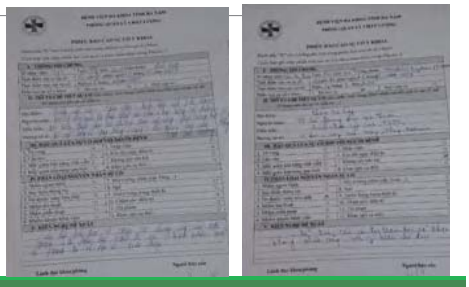
Each department: 1-3 persons

Chief of department, head nurse and some dynamic, enthusiastic members.

Including all departments

INCIDENT ANALYSIS

INCIDENT REPORTING FORM



MEDICAL INCIDENT CLASSIFICATION

Mức ảnh hưởng	Miêu tả	Mức chấn thương và sau đó
Mức 0	Chuẩn bị điều trị sai, tuy nhiên chưa thực hiện trên bệnh nhân (nếu đã thực hiện trên bệnh nhân, có thể đã xảy ra một sai sót)	Không
Mức 1	Thực hiện điều trị sai trên bệnh nhân, tuy nhiên không gây nguy hại gì	Không
Mức 2	Phương pháp điều trị hoặc kiểm soát gây tổn nguy hại tiềm ẩn, hoặc có thể gây ra bất cứ nguy hại nào	Không
Mức 3a	Phương pháp điều trị hoặc kiểm soát cần chăm sóc y tế mức độ nhẹ, như xử trùng, thuốc đắp, hoặc liều thuốc an thần thường không cần thiết trong điều kiện bình thường	Nhẹ (chứng phát sớm)
Mức 3b	Phương pháp điều trị hoặc kiểm soát yêu cầu chăm sóc mức độ cao hơn nhưng không cần thiết trong điều kiện bình thường	Vừa phải, nặng (chứng phát sớm)
Mức 4	Phương pháp điều trị hoặc kiểm soát có thể gây nên nguy hại lâu dài nghiêm trọng có thể ảnh hưởng đến đời sống của bệnh nhân	Nặng (lâu dài)
Mức 5	Phương pháp điều trị hoặc kiểm soát gây tử vong	Tử vong

LIST OF SERIOUS INCIDENTS THAT MUST BE REPORTED

1) Sự cố do phẫu thuật, thủ thuật
- Phẫu thuật nhầm vị trí trên người bệnh
- Phẫu thuật nhầm người bệnh
- Phẫu thuật sai phương pháp trên người bệnh
- Sót gạc dụng cụ
- Tử vong trong hoặc ngay sau khi phẫu thuật thường quy

2) Sự cố do môi trường
- Bị shock do điện giật
- Bị bỏng trong khi điều trị tại bệnh viện
- Cháy nổ (oxy, bình ga, hóa chất độc hại..

3) Sự cố liên quan tới chăm sóc
- Dùng nhầm thuốc (sự cố liên quan 5 đúng)
- Nhầm nhóm máu hoặc sản phẩm của máu
- Sản phụ chuyển dạ hoặc chấn thương đối với sản phụ có nguy cơ thấp
- Bệnh nhân bị ngã trong thời gian nằm viện
- Loét do tỳ đè giai đoạn 3-4 và xuất hiện trong khi nằm viện
- Thụ tinh nhân tạo nhầm tinh trùng hoặc nhầm trứng
- Không chỉ định xét nghiệm, chẩn đoán hình ảnh dẫn đến xử lý không kịp thời
- Hạ đường huyết
- Vàng da ở trẻ trong 28 ngày đầu
- Tai biến do tiêm/chọc dò tủy sống

4) Sự cố liên quan tới quản lý người bệnh
- Giao nhầm trẻ sơ sinh hức xuất viện
- Người bệnh gặp sự cố ỷ khoa ở ngoài cơ sở y tế
- Người bệnh chết do tự tử, tự sát hoặc tự gây hại

5) Sự cố liên quan tới thuốc và thiết bị
- Sử dụng thuốc bị nhiễm khuẩn, thiết bị và chất sinh học
- Sử dụng các thiết bị hỏng/thiếu chính xác trong điều trị và chăm sóc
- Đặt thiết bị gây tắc mạch do không khí

6) Sự cố liên quan tới tội phạm
- Do thầy thuốc, NVYT chỉ định gây sai phạm
- Bắt cóc người bệnh
- Lạm dụng tình dục đối với người bệnh trong cơ sở y tế

CURRENT STATE

1- Benefits of incident reporting were trained to all hospital's core members: the directing board, chiefs and vice chiefs of departments, head nurses (1/6 hospital manpower).

2- Reporting form and procedures for reporting and handling reports were designed.

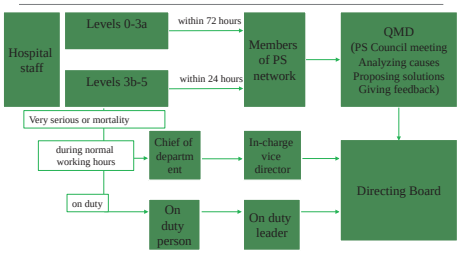
3- An IRS was established in the hospital.

4- Implementation: Very few incident reports, mainly mandatory reports, voluntary reports are rare.

CAUSE ANALYSIS

- Not all hospital staff received trainings and guidance.
  - Those who received training changed their perceptions but have not changed their behaviors.
- Staff did not report voluntarily, did not understand the benefits of reporting and were afraid of punishment.
- The focal points of the system did not work actively.
  - Therefore the system does not operate effectively
- There is no staff in charge of PS
- Personnel changes in the Directing Board.

REPORTING PROCEDURE



SOLUTIONS TO MAINTAIN AND DEVELOP THE SYSTEM

Make the director pay more attention.

Assign an in-charge staff.

Encourage focal people to work more actively

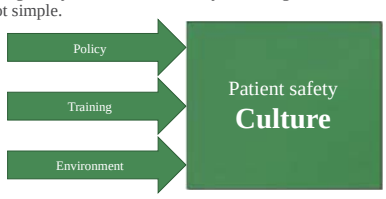
Actively provide information and trainings and show effectiveness.
- Protect reporters
- Analyze root causes of reported incidents and generate warnings so that people see the benefits of reporting.

OBJECTIVES

- 1-2 incident reports are received every day.
- Hospital incident book is published.

Lessons learnt

- Establishing an IRS is not difficult.
- Making the system work effectively and bring real benefits is not simple.




Thank you very much

Session 3

Improving Compliance to Standard Emergengy Response Time from 55% to 85% in December 2016

Dr. Pham Viet Thai

Quality Management Department, Ninh Thuan Provincial General Hospital

1. Reason for choosing the topic

The Vietnam Law of Medical Examination and Treatment (Article 55) states clearly that healthcare workers have the responsibility to examine, diagnose, and indicate treatment in a *timely* manner.

Besides, according to the criterion A1.4 of the Hospital Quality Standards, if the hospital's untimely response to emergency patients causes serious consequences (such as death, limb amputation due to necrosis, unrecoverable injuries...), this criterion is ranked grade 1.

In fact, in the hospital many patients received delayed diagnosis and treatment, which caused serious consequences.

2. Implementation plan

In 2014, the hospital issued regulation on emergency response time for each step in the emergency response process. [1]

Staff were guided to follow the timing regulation.

Checking, monitoring and evaluation of compliance to the timing regulation are conducted monthly and unannounced.

3-a. Current state

A survey was conducted on patients who were admitted in Emergency Department, diagnosed and transferred to inpatient treatment in Ninh Thuan Provincial General Hospital from 4/2015 to 9/2015.

Results of the survey of 600 medical records about emergency response time in the first 24 hours in the hospital in 2015 show that compliance to the standard time was only at 55%.

3-b. Objective

Improving the timeliness of emergency response by increasing the rate of staff compliance to standard emergency response time from 55% to 75% in June 2015 and 85% in December 2015.

4. Cause analysis

Nurses working in internal medicine departments did not know how to arrange their work, which caused delayed specimen collection and transportation.

Some overworking positions due to lack of manpower.

Emergency level was not specified so para-clinical staff did not prioritize the work. Specimen collection technique was not good enough. The regulation on standard emergency response time was not comprehended well. Staff's working spirit was not high enough.

5. Action plan

- Adjusting timing standard for emergency steps.
- Retraining on the current regulation on standard emergency response time.
- Training on specimen collection techniques for nurses.
- Training on 5S all hospital's staff.
- Reviewing personnel, adding nurses for lacking departments.
- Conducting a survey on 300 emergency patients.
- Reevaluating the compliance to standard emergency response time.
- Analyzing root causes of non-compliance.
- Setting objectives and making action plans to continue improvement.
- Reevaluating the compliance to standard emergency response time.

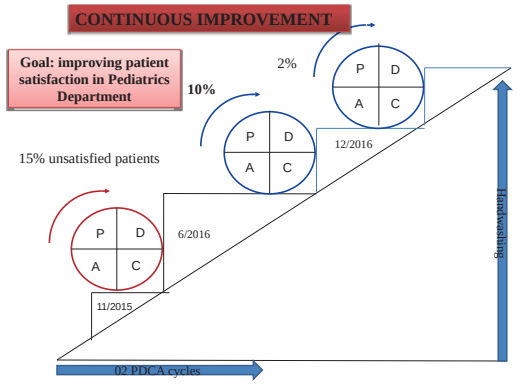
[1] Ninh Thuan Provincial General Hospital (2014). "Procedure for emergency response".

The Vietnam Forum on Quality Management and Patient Safety on January 19th to 21st, 2016.

Enhancing timeliness in emergency response by improving compliance to standard emergency response time from 55% to 85% in December 2016

Dr. Pham Viet Thai, MD.
Chief of Quality Management Department
Ninh Thuan Provincial General Hospital
qlcl.bvninhthuan@gmail.com

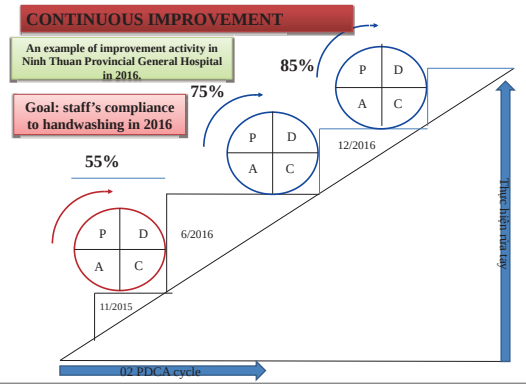
CONTINUOUS IMPROVEMENT



OVERVIEW OF NINH THUAN PROVINCIAL GENERAL HOSPITAL

- 2nd level hospital
- Planned beds: 650
- Actual beds: 868
- 32 departments:
  + 8 functional departments
  + 7 para-clinical departments
  + 17 clinical departments
- Staff: 756

CONTINUOUS IMPROVEMENT



- QMD was established in December 2013.

- Currently there are 06 staff:

  + 01 doctor
  + 01 nurse
  + 02 secondary pharmacists
  + 01 bachelor in hospital management
  + 01 bachelor in information system management

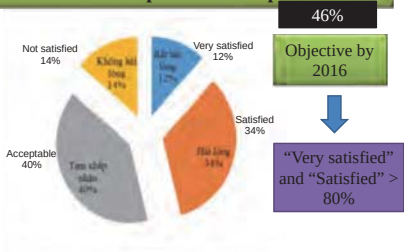
The Vietnam Forum on Quality Management and Patient Safety on January 19th to 21st, 2016.

ENHANCING TIMELINESS IN EMERGENCY RESPONSE BY IMPROVING COMPLIANCE TO STANDARD EMERGENCY RESPONSE TIME FROM 55% TO 85% IN DECEMBER 2016

- Analyzing root causes of non-compliance.

CURRENT STATE

General satisfaction to provincial hospital



Result of satisfaction survey in OPD in 2015, n=1,350

DID YOUR HOSPITAL ISSUE REGULATION ON EMERGENCY RESPONSE TIME?

- When reviewing deaths due to late emergency response, e.g., the nurse forgot to get head CT scan result after the doctor indicates this examination to check subdural hematoma for emergency operation.
- What is timely emergency response?
- Is it necessary to regulate emergency response time?

1. Reasons for choosing the topic

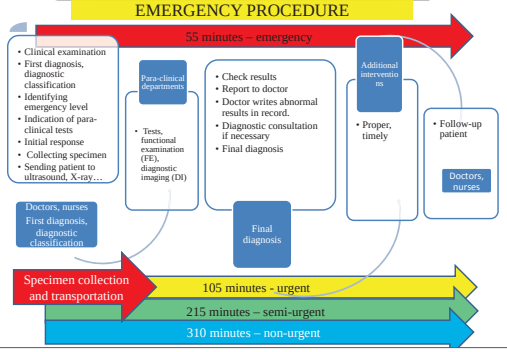
The Vietnam Law of Medical Examination and Treatment (Article 55) states clearly that healthcare workers have the responsibility to examine, diagnose, and indicate treatment in a *timely* manner [2].

According to the criterion A1.4 of the Hospital Quality Standards, if the hospital's untimely response to emergency patients causes serious consequences (such as death, limb amputation due to necrosis, unrecoverable injuries...), this criterion is ranked grade 1 [4].

In fact, in the hospital many patients received delayed diagnosis and treatment, which caused serious consequences [3].

LITERATURE REVIEW

EMERGENCY PROCEDURE



EMERGENCY RESPONSE, INTENSIVE CARE AND POISON CONTROL
(Issued with Decision No. 01/2008/QD-BYT dated 21/01/2008 by the Minister of Health)

Article 2. General requirements

1. Emergency response, intensive care and poison control are very important tasks. 115 emergency units and healthcare institutes must organize emergency response, intensive care and poison control timely in every case.

However, the Decision does not specify time for each step in the emergency procedure.

Literature review

Examination and treatment procedure [5]

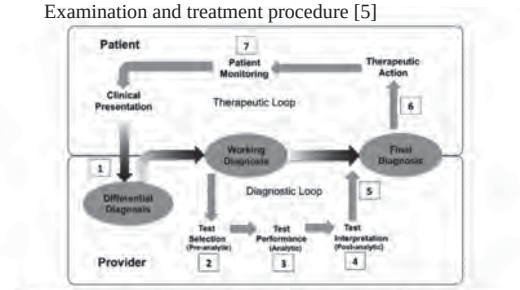


Fig. The conceptual diagram illustrating the diagnostic and therapeutic loops in the diagnostic process.

2. Implementation plan

- In 2014, the hospital issued regulation on emergency response time for each step in the emergency procedure [1].
- Staff were guided to follow the timing regulation.
- Checking, monitoring and evaluation of compliance to the timing regulation are conducted monthly and unannounced.

Literature review

Hospital's regulation on time for each step in the emergency procedure

- **Emergency:** Total time for emergency response in emergency cases, including specimen collection, 01 FE technique and 01 DI technique, is maximum 55 minutes without operation, 60 minutes with operation.
- **Urgent:** Total time for emergency response in urgent cases, including specimen collection, 01 FE technique and 01 DI technique, is maximum 105 minutes without operation, 120 minutes with operation.

LITERATURE REVIEW

DIAGRAM ILLUSTRATING THE DIAGNOSTIC AND THEURAPEUTIC LOOPS IN THE DIAGNOSTIC PROCESS

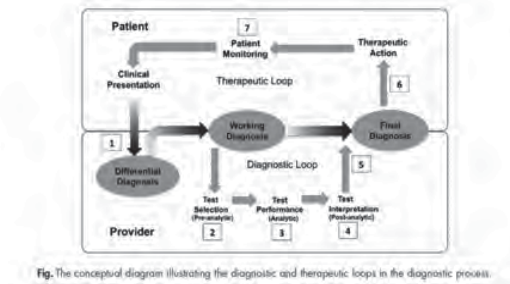


Fig. The conceptual diagram illustrating the diagnostic and therapeutic loops in the diagnostic process.

Literature review

Hospital's regulation on time for each step in the emergency procedure

- **Semi-urgent:** Total time for emergency response in semi-urgent cases, including specimen collection, 01 FE technique and 01 DI technique, is maximum 230 minutes without operation, 260 minutes with operation.
- **Non-urgent:** Total time for emergency response in urgent cases, including specimen collection, 01 FE technique and 01 DI technique, is maximum 310 minutes without operation, 370 minutes with operation.

Literature review

What is non-compliance to emergency response time standard:

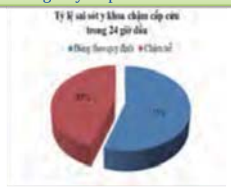
Non-compliance of emergency response time standard is when there are any cases in which emergency response within the first 24 hours does not comply to the timing regulation.

3a. Current state

A survey was conducted on patients who were admitted in Emergency Department, diagnosed and transferred to inpatient treatment in Ninh Thuan Provincial General Hospital from 4/2015 to 9/2015.

Results of the survey of 600 medical records about emergency response time in the first 24 hours in the hospital in 2015 show that

Incompliance to emergency response time standards accounts for 45%.



Literature review

Time standards in the emergency procedure

- Time for doctor to examine and initially handle since receiving patient, calculated based on the time in medical record, is maximum 20 minutes for level 4;
- Time for laboratory tests, calculated based on the time in the result paper attached with the medical record:
+ Time for nurse to collect and send specimen since doctor gives indication is maximum 50 minutes for level 4;
+ Time for test turnaround since specimen is received is maximum 180 minutes for level 4;
+ Time for nurse to check test results and inform doctor to write down abnormal results that affect diagnosis, is maximum 30 minutes for level 4;
+ Time for doctor to intervene after receiving test results is maximum 30 minutes without operation, 90 minutes with operation for level 4.

3a. Current state

Among the results:

- For emergency patients in servere state that need quick emergency response (emergency levels 1, 2): incompliance rate regarding this group was very high (89.2%).

- Internal medicine departments (ICU, 02 internal medicine departments and Pediatrics Department) had incompliance rates of 67%.

- Average time for FE turnaround: 418.3 minutes; DI turnaround: 327.4 minutes; which were much longer than in the regulation.

Literature review

Time standards in the emergency procedure

- Time for FE, ultrasound, endoscopy, ECG, calculated based on the time in the result paper attached with the medical record:
+ Time for nurse to transfer patient to FE or arrange bedside ultrasound, calculated since doctor gives indication, is maximum 60 minutes for level 4;
+ Time for FE turnaround since request or patient is received is maximum 90 minutes for level 4.

3a. Current state

Among the results:

- Specimen collection and transportation account for 70%.

- Patients above 60 years old account for 76.1%.

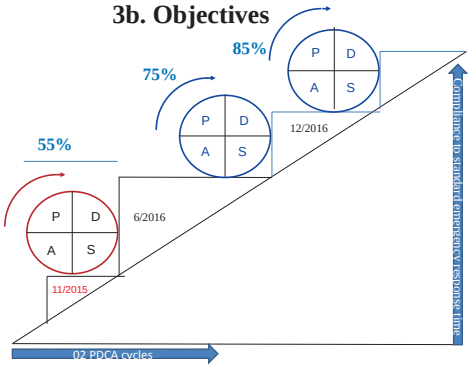
- Most patients were hospitalized out of normal working time (77.5%) but the incompliance rates towards patients received during and out of normal working time are not statistically significant. Which means incompliance tends to associate with staff's discipline rather than the number of healthcare workers, or there may be something wrong in work division during normal working hour.

Literature review

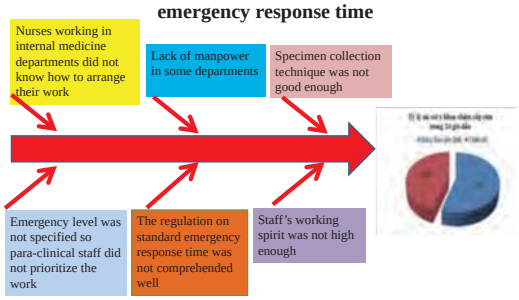
Time standards in the emergency procedure

- Time for DI, X-ray, CT, MRI, calculated based on the time in the result paper attached with the medical record:
+ Time for nurse to transport patient to DI or arranged bedside X-ray, calculated since doctor finishes examination, is maximum 60 minutes for level 4;
+ Time for DI turnaround since request or patient is received is maximum 90 minutes for level 4.
- Time for nurse to report results to doctor and doctor to intervene after receiving FE and DI results, calculated based on the time in the medical record, is maximum 30 minutes without operation, 90 minutes with operation for level 4.

3b. Objectives



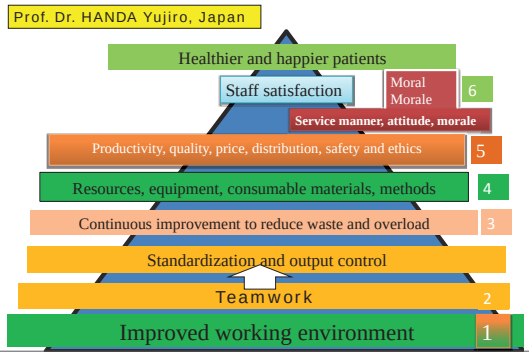
4. Causes of incompliance to standard emergency response time



5. Action plan

No.	Activities	Responsibility	Time	Implemented
5	Review manpower, adding nurses for lacking departments	Manpower Development Council	01/2016	
6	Conducting a survey on 300 emergency patients	QMD	03-06	
7	Reevaluating the compliance to standard emergency response time. Analyzing root causes of non-compliance.	QMD IT Department	6/2016	
8	Setting objectives and making action plans to continue improvement.	Dr. Thai	7/2016	
9	Reevaluating the compliance to standard emergency response time. Analyzing root causes of non-compliance.	QMD IT Department	12/2016	

06 BASIC ISSUES MAKING PATIENTS SATISFIED



SURVEY DESIGN

Target of study: Inpatients in Ninh Thuan Provincial General Hospital from March to October 2016.

Study method: Descriptive, cross sectional study with analysis

Sample size: Calculated by the formula:

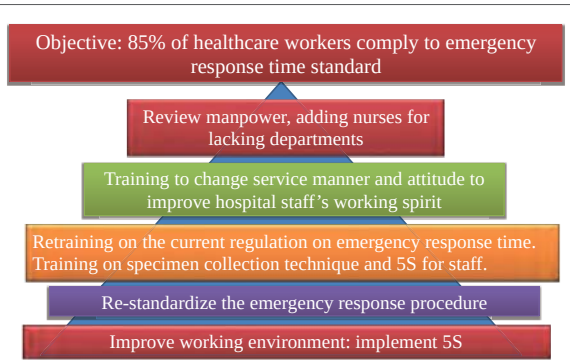
$$n = \frac{Z^2_{(1-\alpha/2)}\, p\,(1-p)}{d^2}$$

Of which: $\alpha = 0.05$: confidence interval 95%, $Z_{(1-\alpha/2)} = 1.96$

d: acceptable error (desired precision) is 4% → d = 0.04

p = 0.85 : compliance rate to standard timing

From the above formula, n # 300



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[1] Ninh Thuan Provincial General Hospital (2014). "Procedure for emergency response".
[2] Vietnam Law on Medical Examination and Treatment – No. 40/2009/QH12.
[3] Archive of minutes/reports of technical reviews and medical record reviews in Ninh Thuan Provincial General Hospital in 2014.
[4] Hospital Quality Standards (Issued with Decision no. 4858/QD-BYT dated 03 December 2013 by the Minister of Health).
[5] Satid Thammasitboon, MD, Supat Thammasitboon, MD, Geeta Singhal, MD. System-Related Factors Contributing to Diagnostic Errors. Curr Probl Pediatr Adolesc Health Care. 2013 Oct; 43(9):242-7. doi: 10.1016/j.cppeds.2013.07.004. Review. Erratum in: Curr Probl Pediatr Adolesc Health Care. 2014 Feb;44(2):52. PMID: 24070581.

5. Action plan

No.	Activities	Responsibility	Time	Implemented
1	Adjusting the regulation on time standard for each step in the emergency procedure	Scientific Council	2/2015	
2	Retraining on the hospital's regulation on standard emergency response time	Dr. Thai	02/2016	
3	Training on specimen collection techniques for nurses	Nursing Department, Laboratory	2/2015	
4	Training on 5S knowledge for staff	5S Committee	01-02/2016	

THANK YOU FOR YOUR ATTENTION

A Topic from Japan

Eight Core Values in Quality Management in Japan

Shinsuke Murai

Bureau of International Health Cooperation, NCGM, Japan

Japanese products are known by their quality in the world. In industry, service and healthcare sectors, Japanese people share core values in QM. Yamanote Subway and Udon noodle restaurant work with the same core values in their management of quality and services. These core values are the principles of QM.

There are eight typical core values in Japan. (1) “Quality first” means that our top work goal is to provide quality services. (2) “Customer oriented” means using customers’ expectations to set objectives for service quality. Customers’ demands are reflected in your services. However, in hospitals we also need to consider quality of clinical work, of which objectives are from medical knowledge. (3) “Vital few (prioritization)” implies a concentration on the few that affect much quality. We cannot work for everything. For example, importance and urgency are different matters. (4) “The next process is also your customer” means that staff in your hospital are also customers. For example, staff in charge of medical equipment and materials need to think about how to provide best services to doctors and nurses in the hospital.” (5) “Quality must be built in process” says that the services provided to patients are accumulated results of a series of inter-related activities in the hospital. What we need to improve is not result but the process that produced bad results. (6) “Management by facts” or “Talk with facts (data)” means that our decisions should not rely only on our intuition, experience and braveness (KKD) but should also rely on facts that are confirmable. Facts are easy to share among team members. (7) “Failures are a treasure land (learn from failures)” means that failure analysis is for prevention of repeating the same failure in another day. To promote “learning from failure”, a learning culture should be fostered in your organization. (8) “Respect for humanity (participatory QI)” says that nobody is born a bad person. We trust and rely on people. Teamwork will enhance your QI capability, as you involve people with different responsibilities in the process.

Most of these eight core values are not new to Vietnam. Core values exist in our culture and daily life.


Vietnam Forum on Quality Management and Patient Safety 2016

Bach Mai Hospital 20-21/01/2016

Eight core values in quality management in Japan

Program for International Promotion of Japan’s Healthcare Technologies and Services
Strengthening Healthcare Staff’s Capability of Quality Management in Healthcare in Viet Nam

NCGM

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Core value 1

Quality first

We work for **Quality**
Money comes after that

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Core value 2

Customer oriented

"Customer is
God"

Saying in Japanese industry

©Shinsuke Murai 18

Are you customer?

Do you know what customers want?

To think of "Quality"
is to think of "Objectives"

(Naruo UEHARA, 1993)

Definitions of Quality

- Quality is the element of something that guarantees achievement of objectives or expected outcomes
- Quality is measured by the degree of achievement of objectives

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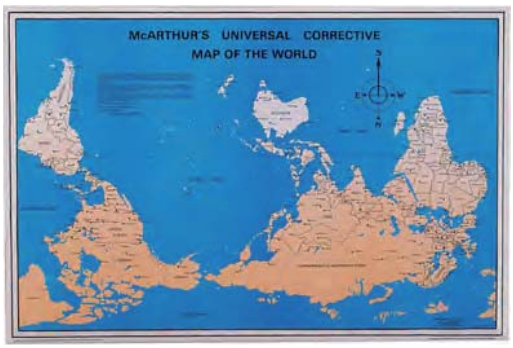

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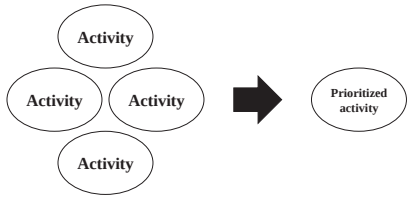
Core value 3:

Vital few

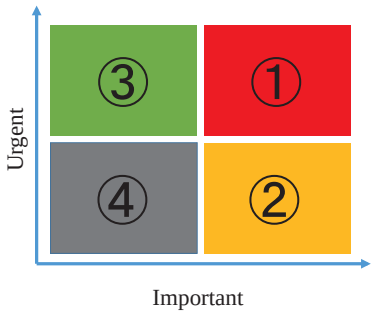


Core value 4:

The next process is still **customer**

Doctor	Pharmacist	Nurse	Patient
Error in indication	Request wrong drug	Wrong drug	Patient takes wrong drug

Engineer	Doctor	Doctor	Patient
Rarely take care of medical equipment	Request examination	Machine doesn't work	Patient is not examined

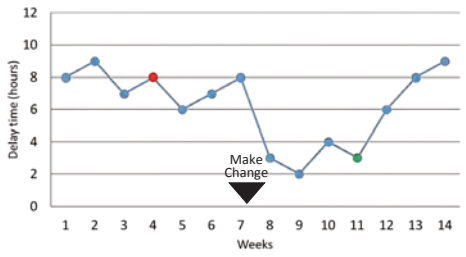


Core value 5:

Quality must be built in the process

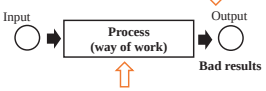
- The number of defects isn't going down! What's going wrong?
- Although we've given strict orders of the goal to be achieved, we still can't achieve our targets!
- I've told them again and again to follow the safety procedures, but they still commit accidents!

David William and Azhar Ali (HI). Improvement Capability. In International Forum on Chất lượng and Safety in Healthcare . Seminar. 2015. September 28.



Quality is built in process

People tend to concentrate exclusively on the **result**.



People forget about the **process** that produced the bad result.

Hosotani, K. 1989

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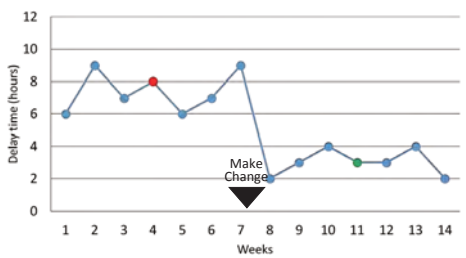
Provost LP, Murray SK. The Healthcare Data Guide: Learning From Data for Improvement. San Francisco, CA: Jossey-Bass; 2011, Page 16.



Wrong design (way of work) will cause bad result

"The Design of Everyday Things" (2002)

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Core value 6:

Management by facts

Before

KKD (勘、経験、度胸)

Kan Intuition　Keiken Experience　Dokyo Braveness

Later

Talk to facts

Core value 8:

Respect humanity

Your responsibility + Others' responsibilities → Can tackle bigger problems

Participatory quality improvement

Asakusa temple has lanterns
Asakusa temple is beautiful

Eight core values in quality management in Japan

1. Quality culture (Quality first)
2. Customer-oriented (From manufacturing – to market)
3. Vital few (Prioritization)
4. The next process is still customer
   (Way of thinking)
1. Management by facts (Fact-based decision making)
2. Respect humanity (Participation)
3. Quality must be built in the process (System thinking)
4. Errors (defects) are treasure (improvement opportunities)

Core value 7:

Errors are treasure

Problems

||

Improvement opportunities

Core values are easy to talk about but difficult to implement

But not impossible,

As we see efforts in this forum

Core value 8:

Respect humanity

Your responsibility → Can tackle small problems

Narrow

Wide

Eight

Session 4

Plan to Improve Management and Medical Safety in Prescription for Outpatients

Tran Quang Hien

An Giang Hospital of Obstetrics, Gynecology and Pediatrics

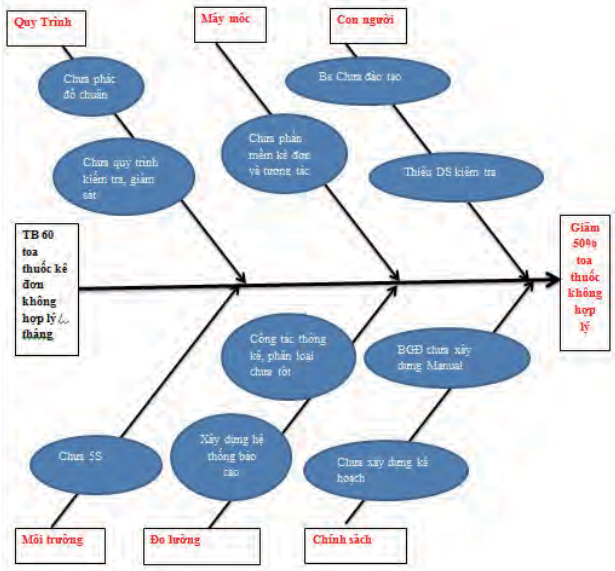
1. Reason for choosing the topic

Our provincial general hospital receives about 1,000 outpatient visits a day. A study shows that on average there were about 60 inappropriate prescriptions out of 120 randomly selected prescriptions, accounting for about 50% of prescriptions that didn't follow treatment protocols, such as wrong dose, interacting drugs, wrong indication and unnecessary drugs… This may affect patient's health, increase medical costs and cause medical errors if there are no interventions.

2. Objective

Inappropriate prescriptions in OPD are reduced by 50% from 2nd quarter of 2015.

3. Identifying causes of errors in prescription



4. Solutions

4.1. Personnel:

- Training and updating treatment protocols

- Reinforcing prescription check by pharmacists (double check)

4.2. Machine:

- Employing a prescription software that can check drug interactions.

4.3. Procedure:

- Issuing standard operation procedure (SOP)

- SOP for prescription check and monitoring

4.4. Environment:

- Implementing 5S

4.5. Measurement:

- Developing reporting and statistics system

4.6. Policy:

- Developing pharmaceutical manual

- Issuing plan

5. Division of work

TIẾN ĐỘ THỰC HIỆN KẾ HOẠCH

Công việc	Nội dung	Thời gian cần thiết	Ngày bắt đầu	Công việc hoàn thành trước	Tiến độ thực hiện (tuần)												Thực hiện
					1	2	3	4	5	6	7	8	9	10	11	12	
A	Xây dựng và ban hành kế hoạch	1 W	1/7/2015		x												KHTH
B	Xây dựng Phác đồ, Manual và các SOP	1 M		A		x	x	x	x								KHTH + Dược
C	Trang bị phần mềm tương tác thuốc	2 W		A	x	x											TBYT
D	Bổ sung 2 Ds kiểm tra đơn (Double check)	1 M		A	x	x	x	x									TCCB + Dược
E	Thực hiện 5S	2 W		A		x	x										HCQT
F	Xây dựng hệ thống báo cáo	2 W		AB		x	x										KHTH
G	Tập huấn	1 W		ABCD				x									KHTH + Dược
H	Kiểm tra, giám sát	3 W		EFG				x			x					x	KHTH + Dược
I	Thống kê, phân tích	3 W		H				X			X					X	KHTH
J	Sơ kết báo cáo	1 W		I												X	KHTH
K	Tổng kết và đánh giá mục tiêu	1 W		J												x	BGĐ

6. Implementation

1. Issuing policy

- The directing board issued implementation plan;

- The director issued documents on updating and developing new treatment protocols based on the hospital's disease pattern, MOH's documents and evidence based medicine (EBM);

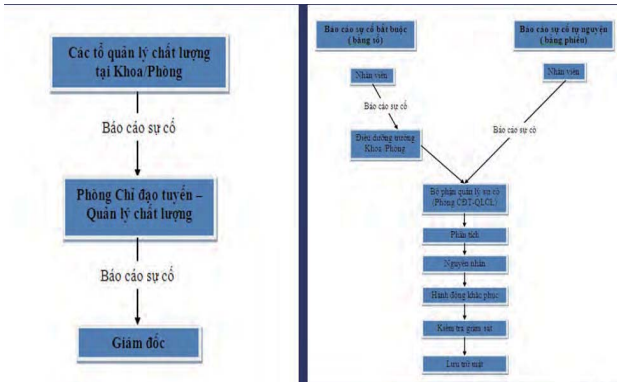
2. Applying information technology

- Hsoft, which can check drug interactions for OPD, has been employed

3. Implementing 5S

- Drug stores and pharmacies have been arranged following 5S.

4. Developing reporting system:



5. Training, checking, monitoring

After the plan was issued, QMD have been conducting trainings, monitoring quality indicators, and monitoring implementation.

7. Achieved results

Compliance rates to treatment protocols	Month				
	July	August	September	October	November
Total outpatient turns	40,173	36,658	36,789	41,031	38,526
Outpatient turns in internal medicine	22,810	20,931	20,460	22,004	20,864
Compliance rates to treatment protocols (%)	57	80	93	73	83

ABC/VEN analysis and outpatient prescription review from July 2015 to present:

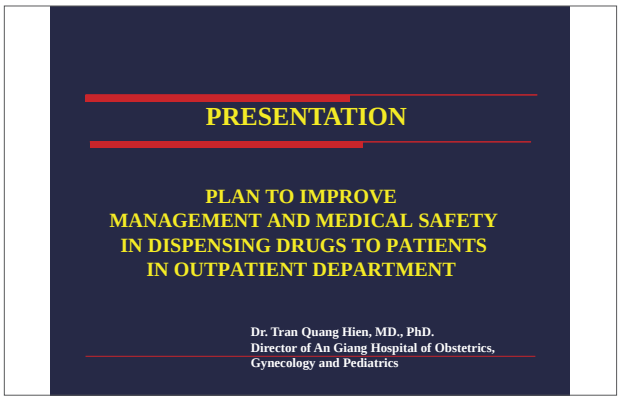
Results:

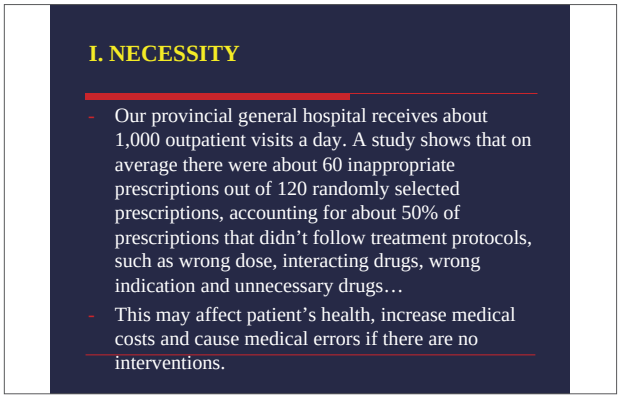
+ The number of prescriptions with mistakes reduced 25% on average.

+ Outpatient prescription indicator: decreased from 6.2 to 2.75.

+ Drugs cost reduced from 72% (2013) to 62% (2015)

+ Antibiotics cost: reduced from 60 billion (2013) to 39 billion (2015).





II. OBJECTIVE

Inappropriate prescriptions in OPD are reduced by 50% from 2nd quarter of 2015.

III. CAUSE IDENTIFICATION

IV. SOLUTIONS

1. Personnel:
- Training and updating treatment protocols
- Reinforcing prescription check by pharmacists (double check)

2. Machine:
- Employing a prescription software that can check drug interactions.

IV. SOLUTIONS (2)

3. Procedure:
- Issuing standard operation procedure (SOP)
- SOP for prescription check and monitoring

4. Environment:
- Implementing 5S

IV. SOLUTIONS (3)

5. Measurement:
- Developing reporting and statistics system

6. Policy:
- Developing pharmaceutical manual
- Issuing plan

V. WORK DIVISION AND PROGRESS

TIẾN ĐỘ THỰC HIỆN KẾ HOẠCH

Công việc	Nội dung	Thời gian cần thiết	Ngày bắt đầu	Công việc hoàn thành trước	Tiến độ thực hiện (tuần) 1	2	3	4	5	6	7	8	9	10	11	12	Thực hiện
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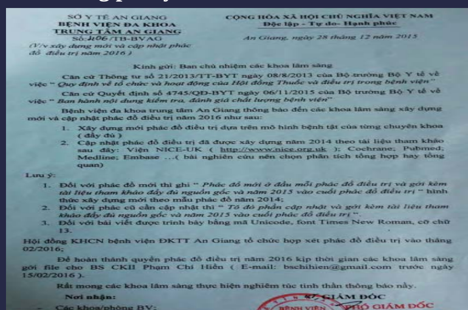
B	Xây dựng Phác đồ, Manual và các SOP	1 M		A		x	x	x	x								KHTH + Dược
C	Trang bị phần mềm tương tác thuốc	2 W		A	x	x											TBYT
D	Bổ sung 2 Ds kiểm tra đơn (Double check)	1 M		A	x	x	x	x									TCCB + Dược
E	Thực hiện 5S	2 W		A		x	x										HCQT
F	Xây dựng hệ thống báo cáo	2 W		AB		x	x										KHTH
G	Tập huấn	1 W		ABCD				x									KHTH + Dược
H	Kiểm tra, giám sát	3 W		EFG				x				x				x	KHTH + Dược
I	Thống kê, phân tích	3 W		H				X				X				X	KHTH
J	Sơ kết báo cáo	1 W		I												X	KHTH
K	Tổng kết và đánh giá mục tiêu	1 W		J												x	BGĐ

VI. Implementation

A. Issuing policy



SỞ Y TẾ AN GIANG
BỆNH VIỆN ĐA KHOA TRUNG TÂM AN GIANG
Số: 1106 /TB-BVAG
(V/v xây dựng mới và cập nhật phác đồ điều trị năm 2016)

CỘNG HÒA XÃ HỘI CHỦ NGHĨA VIỆT NAM
Độc lập - Tự do- Hạnh phúc
An Giang, ngày 28 tháng 12 năm 2015

Kính gửi: Ban chủ nhiệm các khoa lâm sàng

Căn cứ Thông tư số 21/2013/TT-BYT ngày 08/8/2013 của Bộ trưởng Bộ Y tế về việc " *Quy định về tổ chức và hoạt động của Hội đồng Thuốc và điều trị trong bệnh viện* "

Căn cứ Quyết định số 4745/QĐ-BYT ngày 06/11/2015 của Bộ trưởng Bộ Y tế về việc " *Ban hành nội dung kiểm tra, đánh giá chất lượng bệnh viện* "

Bệnh viện đa khoa trung tâm An Giang thông báo đến các khoa lâm sàng xây dựng mới và cập nhật phác đồ điều trị năm 2016 như sau:

1. Xây dựng mới phác đồ điều trị dựa trên mô hình bệnh tật của từng chuyên khoa (đầy đủ)
2. Cập nhật phác đồ điều trị đã được xây dựng năm 2014 theo tài liệu tham khảo sau đây: Viện NICE-UK (http://www.nice.org.uk); Cochrane; Pubmed; Medline; Embase ...(bài nghiên cứu nên chọn phân tích tổng hợp hay tổng quan)

Lưu ý:

1. Đối với phác đồ mới thì ghi " *Phác đồ mới ở đầu mỗi phác đồ điều trị và gởi kèm tài liệu tham khảo đầy đủ nguồn gốc và năm 2015 vào cuối phác đồ điều trị* " hình thức xây dựng mới theo mẫu phác đồ năm 2014;
2. Đối với phác cũ cần cập nhật thì " *Tô đỏ phần cập nhật và gởi kèm tài liệu tham khảo đầy đủ nguồn gốc và năm 2015 vào cuối phác đồ điều trị* ".
3. Đối với bài viết được trình bày bằng mã Unicode, font Times New Roman, cỡ chữ 13.

Hội đồng KHCN bệnh viện ĐKTT An Giang tổ chức họp xét phác đồ điều trị vào tháng 02/2016;

Để hoàn thành quyển phác đồ điều trị năm 2016 kịp thời gian các khoa lâm sàng gởi file cho BS CKII Phạm Chí Hiền (E-mail: bschihien@gmail.com trước ngày 15/02/2016).

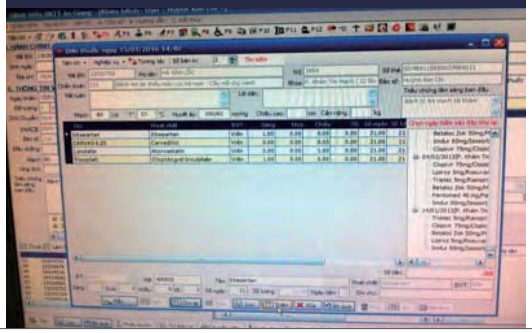
Rất mong các khoa lâm sàng thực hiện nghiêm túc tinh thần thông báo này.

Nơi nhận:
- Các khoa/phòng BV;

KT. GIÁM ĐỐC
PHÓ GIÁM ĐỐC

B. Developing protocols and SOPs

C. Prescription software



G. ABC/VEN analysis

PHÂN TÍCH ABC/VEN SỬ DỤNG THUỐC HAI NĂM 2013-2014
BỆNH VIỆN ĐA KHOA TRUNG TÂM AN GIANG

Ts.Bs Trần Quang Hiển - ThS.Ds Nguyễn Thiện Trí

TÓM TẮT

Mục tiêu: *Phân tích sử dụng thuốc tại Bệnh viện hai năm 2013-2014 theo phân loại ABC, VEN nhằm định hướng lựa chọn sử dụng thuốc trước và sau can thiệp.*

Phương pháp: *nghiên cứu hồi cứu mô tả dựa trên ma trận ABC/VEN, tiến hành phân tích hiệu quả kinh tế trong việc sử dụng thuốc hai năm 2013-2014 Bệnh viện đa khoa trung tâm An Giang.*

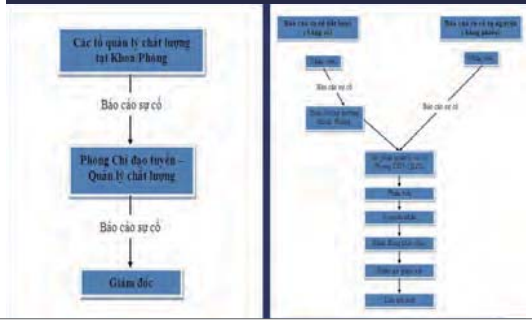
Kết quả: *Qua hai năm (2013-2014) có (576-1210) thuốc được sử dụng trong bệnh viện. Tổng chi phí thuốc sử dụng là (135.714.421.261-159.174.649.041) đồng, trong đó có (66-107) loại thuốc (11,468%-8,84%) được xếp nhóm A nhưng chiếm đến (70,95%-70,11%) chi phí sử dụng thuốc, trong (112-188) loại thuốc (19,44%-15,54%) thuộc nhóm B chiếm (19,96%-19,92%) chi phí sử dụng thuốc, còn lại (398-915) loại thuốc chiếm (69,1096-75,629%) thuộc nhóm C chỉ chiếm (9,09%-9,97%) chi phí sử dụng thuốc trong bệnh viện. Phân tích VEN cho thấy (30-183) loại thuốc chiếm (8,68%-15,29%) là thuốc tối cần thiết (Nhóm V), (492-965) loại thuốc chiếm (85,429%-79,75%) là thuốc thiết yếu (Nhóm E), còn lại (34-60) loại thuốc (5,90%-4,96%) là thuốc không thiết yếu (Nhóm N). Trong phân tích ma trận ABC/VEN, thuốc phân thành Loại I (AV+BV+AE+AN) có (109-270) loại chiếm (18,92%-22,31%), Loại II (BE+CE+BN) có (443-898) loại chiếm (76,91%-74,21%) và loại III (CN) có (24-42) loại chiếm (4,17%-3,47%). Quản lý thuốc Loại I được theo dõi chặt chẽ để kiểm soát sử dụng thuốc hàng năm được tốt hơn, đồng thời kiểm soát thuốc loại II ở mức trung bình và hạ mức thấp hơn sử dụng thuốc loại III.*

D. Implementing 5S

TOA THUỐC

TOA THUỐC

E. Developing reporting system



TOA THUỐC

TOA THUỐC

F. Training and checking

TOA THUỐC

TOA THUỐC

H. Results

Compliance rates to treatment protocols	Month				
	July	August	September	October	November
Total outpatient turns	40,173	36,658	36,789	41,031	38,526
Outpatient turns in internal medicine	22,810	20,931	20,460	22,004	20,864
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H. Results

ABC/VEN analysis and outpatient prescription review from July 2015 to present:

Results:

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+ Outpatient prescription indicator: decreased from 6.2 to 2.75.

+ Drugs cost reduced from 72% (2013) to 62% (2015)

+ Antibiotics cost: reduced from 60 billion (2013) to 39 billion (2015).

Session 5-1

5S Implementation in Two Departments in Ninh Binh Provincial General Hospital

(NEPHRO-UROLOGICAL SURGERY AND ENDOCRINOLOGY DEPARTMENTS)

Vu Thuy Giang

Quality Management Department, Ninh Binh Provincial General Hospital

1. Reason for choosing the topic

The hospital expects to improve quality through developing a logical, convenient and effective working environment to contribute to enhance the spirit and working manner of medical staff and to build a good image for the hospital. After successful implementation of 5S in two departments, it will be expanded to all departments.

2. State before implementation

- The number of patients and patient family members who take care of the patients is large, the workload of medical staff is huge, leading to disordered work environment, redundancy of items not handled and untidy workplaces. The arrangement is not logical enough, causing healthcare workers spend more time to find necessary things for their work.

- 5S evaluation scores (using the checklist developed by the QMD):

Nephro-Urological Surgery Department: 54/100 points

Endocrinology Department: 48/100 points

3. Objective

After 3 months of implementation, from January to March 2016, the two departments achieve more than 80 points in 5S score.

4. 5S implementation plan

December 2015

- QMD makes and submit the plan to the directing board for approval.

- Establish 5S Steering Committee and task force

- QMD develops a 5S checklist and guidelines for implementation.

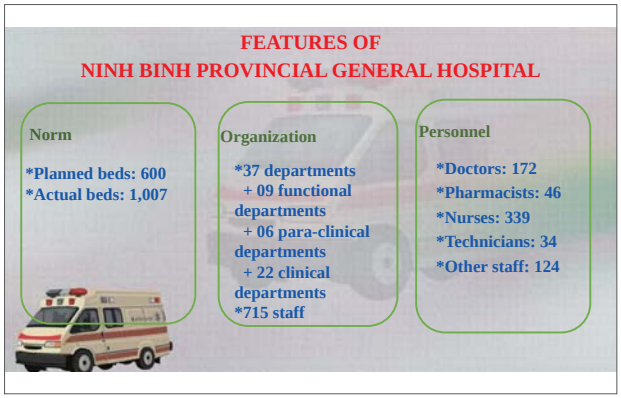
- Evaluating current state

From January to March 2016

- Week 1: Guiding the two departments to implement 5S

- Week 2 to week 10: The task force evaluates using the 5S checklist twice a week and gives advice to 5S implementation.

- Week 11 and 12: Summarizing the results of 5S implementation in the two departments, reporting to the Steering Committee to generate lessons leant and direction for expansion in the entire hospital.



INTRODUCTION OF QMD

QMD was established in November 2014 with 10 staff, including:

-2 first degree specialists

-1 master of pharmacy

-1 master of IT

-1 environmental technology engineer

-1 college nurse

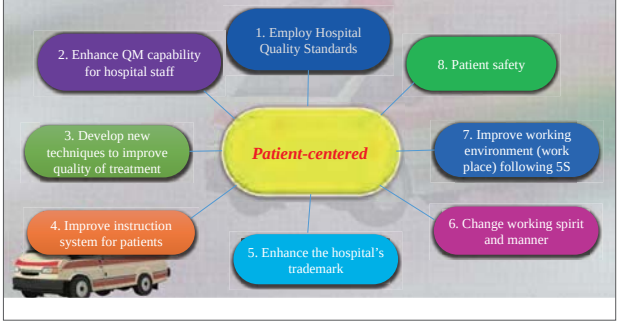
-2 secondary nurses

-2 other staff

Actual state before implementation

- The number of patients and patient family members who take care of the patients is large, the workload of medical staff is huge, leading to disordered work environment, redundancy of items not handled and untidy workplaces. The arrangement is not logical enough, causing healthcare workers spend more time to find necessary things for their work.
- 5S evaluation scores (using the checklist developed by the QMD):
  Nephro-Urological Surgery Department: 54/100 points
  Endocrinology Department: 48/100 points

CONTINUOUS QUALITY IMPROVEMENT (CQI)



Objectives

After 3 months of implementation, from January to March 2016, the two departments achieve more than 80 points in 5S score.

5S implementation plan

December 2015

- QMD makes and submit the plan to the directing board for approval.
- Establish 5S Steering Committee and task force
- QMD develops a 5S checklist and guidelines for implementation.
- Evaluating current state

Reasons for choosing the topic

The hospital expects to improve quality through developing a logical, convenient and effective working environment to contribute to enhance the spirit and working manner of medical staff and to build a good image for the hospital. After successful implementation of 5S in two departments, it will be expanded to all departments.

5S implementation plan

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- Week 1: Guiding the two departments to implement 5S
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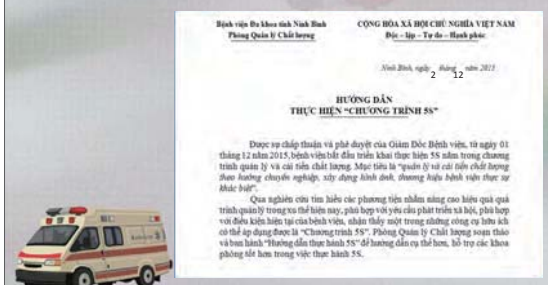
5S guidelines



Bệnh viện Đa khoa tỉnh Ninh Bình
Phòng Quản lý Chất lượng

CỘNG HÒA XÃ HỘI CHỦ NGHĨA VIỆT NAM
Độc – lập – Tự do – Hạnh phúc

Ninh Bình, ngày 2 tháng 12 năm 2015

HƯỚNG DẪN
THỰC HIỆN "CHƯƠNG TRÌNH 5S"

Được sự chấp thuận và phê duyệt của Giám Đốc Bệnh viện, từ ngày 01 tháng 12 năm 2015, bệnh viện bắt đầu triển khai thực hiện 5S năm trong chương trình quản lý và cải tiến chất lượng. Mục tiêu là "*quản lý và cải tiến chất lượng theo hướng chuyên nghiệp, xây dựng hình ảnh, thương hiệu bệnh viện thực sự khác biệt*".

Qua nghiên cứu tìm hiểu các phương tiện nhằm nâng cao hiệu quả quá trình quản lý trong xu thế hiện nay, phù hợp với yêu cầu phát triển xã hội, phù hợp với điều kiện hiện tại của bệnh viện, nhận thấy một trong những công cụ hữu ích có thể áp dụng được là "Chương trình 5S". Phòng Quản lý Chất lượng soạn thảo và ban hành "Hướng dẫn thực hành 5S" để hướng dẫn cụ thể hơn, hỗ trợ các khoa phòng tốt hơn trong việc thực hành 5S.

Pilot implementation in two departments and compare between before and after implementation

Before

After

5S evaluation checklist

Department:				Total score:					
Evaluator:			Date of evaluation:						
Place	#	Item	Evaluation contents	Score					
				1	2	3	4	5	
Administrative room	1	Desks/Chairs	Are they clean and tidy?						
	2	Cabinets	Are they clean and labelled clearly?						
	3	Medical records, X-ray films, notebooks, documents, stationary	Are they clean, stored and placed logically?						
	4	Computers, printers, telephones, wire, cable wire and other equipment	Are they clean, tidy, suitable and well-maintained?						
	5	Lamps, air-conditioners, fans	Are they clean, safe and arranged appropriately? Do they work?						
	6	Walls, windows, floor, ceiling	Are they clean and well-maintained?						
	7	Information boards and papers attached to the wall	Are they clean, arranged appropriately and updated?						
Wards	8	Beds (blanket, bed sheet, pillow)	Are they clean and tidy?						
	9	Bedside cabinets	Are they clean and tidy?						

Before

After

Place	#	Items	Contents of evaluation	Score				
				1	2	3	4	5
Wards	10	Medical equipment	Are they clean, tidy and in good condition?					
	11	Lamps, air-conditioners, fans	Are they clean, safe and arranged appropriately? Do they work?					
	12	Walls, windows, floor, ceiling	Are they clean and well-maintained?					
Injection and procedure room	13	Injection trolleys	Are they clean and organized tidily and logically?					
	14	Drug cabinets	Are they clean, labelled for classification?					
	15	Cabinets and shelves	Are they clean, labelled for classification?					
	16	Medical equipment	Are they clean, tidy and in good condition?					
	17	Lamps, air-conditioners, fans	Are they clean, safe and arranged appropriately? Do they work?					
	18	Walls, windows, floor, ceiling	Are they clean and well-maintained?					
Wards	19	Drug cabinets	Are things in the storage organized logically, easy to find and easy to get?					
	20	Medical waste, unused things	Are they separated, arranged logically and labelled red following the regulation?					

Difficulties and challenges in implementing 5S program

* 5S is a new concept and not well known, which came to Vietnam 10 years ago but not many healthcare facilities have applied it. Therefore it is difficult to explain and convince people to implement.
* Compliance and working manner is not so good at working places, which is difficult to change in a short time
* Staff have not received systematic trainings, detailed instructions and consultancy from experts.
* Limited budget to improve the working environment (work place)

Evaluation of actual state and images before implementation

Proposed solutions

- Increasing 5S knowledge :
  - Conducting training courses
  - Giving direct instructions in departments
  - Providing 5S materials and pictures
- Organizing contests of 5S implementation
- Strengthening 5S monitoring in departments


THANK YOU VERY MUCH

Session 5-2

5S Implementation in Ha Dong General Hospital

Nguyen Thi Huong Lien

Quality Management Department, Ha Dong General Hospital

1. Reason for choosing the topic

At present, departments in our hospital (including three laboratories) are not arranged in tidy manner, many unused things are not placed in order. Therefore, to ensure effective work and comfortable working environment, I decide to implement 5S in three laboratories: Hematology–Blood Transfusion, Biochemistry, and Microbiology from December 2015 to May 2016 (6 months).

2. Implementation plan

Time: 12/2015

2.1. Establishing a 5S Steering Committee including 17 members.

The director or a vice director is the chairman, chiefs of functional departments, 3 laboratories, Pharmacy Department, Infection Control Department are members.

Responsibilities: developing and implementing a 5S program in the three laboratories.

2.2. Studying actual state of the three laboratories (with taking pictures):

- Facility:

- Human resource:

- Working environment and condition:

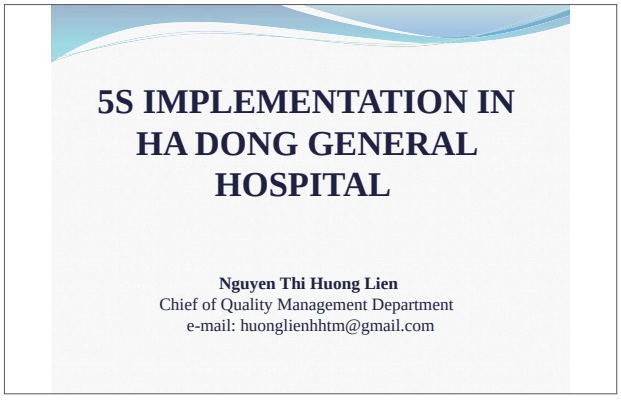
Time: 01/2016

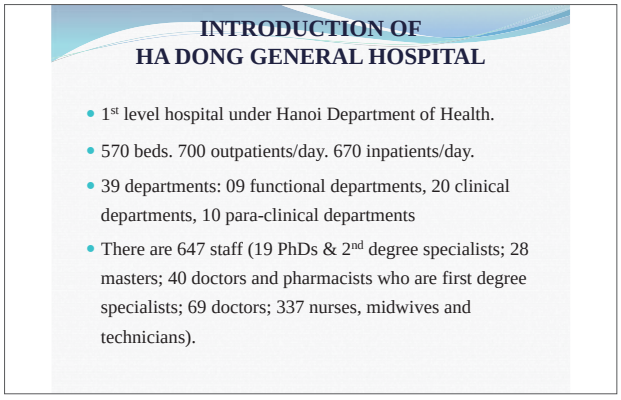
2.3. Training on 5S for the Steering Committee and all staff of the three laboratories.

2.4. Implementing 5S: under current condition.

3. Objective

To develop a habit of applying 5S in the three laboratories.





QM System

- QM unit: July 2014

QM System

- QM Council: 22 people, including chiefs of departments and some clinical departments.
- QM Network: 1 staff/department

A QI plan has been developed and implemented.

- Quarterly evaluation of the quality of departments in 2015 using MOH's "Hospital Quality Standards"
- QM monitoring activities are integrated with regular monitoring activities of the hospital every Wednesday afternoon.

Reasons for choosing the topic

- Departments in our hospital (including three laboratories) are not arranged in tidy manner, many unused things are not placed in order.
- To ensure effective work and comfortable working environment, it needs to implement 5S in three laboratories: Hematology–Blood Transfusion, Biochemistry, and Microbiology from December 2015 to May 2016 (6 months). After that, it should be expanded to the whole hospital.

Reasons for choosing the topic

- 5S can improve the mood, improve working condition and atmosphere, and complete the working environment.
- 5S is an improvement method that is simple, easy to understand, easy to implement, not costly but very effective in mobilizing manpower; increasing productivity, quality and effectiveness; and reduce waste.

Actual state before implementing 5S

- As a satellite hospital of Bach Mai hospital: 12 departments were implementing ISO.
- The hospital was employing MOH's HQS.

=> Since October 2015: there have been remarkable changes.

Actual state of hospital

- Hospital has been implementing "Hygienic hospital" and hanging hygiene slogans in departments.
- The hospital director requests departments to actively implement 5S.
- The hospital established a steering committee to liquidate broken or unused properties.

Actual state in three laboratories

- *Facility*: narrow rooms, lack of computers and printers, no cabinets nor shelves for documents, procedures, etc.
- *Manpower*: not well aware of organizing and arrangement in rooms, not recognize benefits of 5S implementation; shortage of manpower so they have to cover different jobs.
- *Environment*: Untidy and illogical arrangement; many unnecessary things in the working space.

3. Objective

To develop a habit of applying 5S in the three laboratories:

Hematology-Blood Transfusion, Biochemistry,

Microbiology Departments.

Actual state of 5S implementation in the hospital

Waiting area for patient family

4. 5S implementation plan

- In December 2015:

+ Establishing a 5S Steering Committee including the director or a vice director as the chairman, chiefs of departments (3 laboratories) are members.

Responsibilities: developing and implementing a 5S program in the three laboratories.

+ Studying actual state of the three laboratories (with taking pictures):

- Facility
- Human resource
- Working environment and condition

Actual state of hospital

Setting up centralized linen storage

- January to March 2016:

+ Training on 5S and internal evaluation for the Steering Committee and all staff of the three laboratories.

+ Implement 5S in the 3 laboratories:

Under current condition: facility, equipment

+ Monitoring – evaluation:

Internal evaluation group

❖ Report

- May 2016:

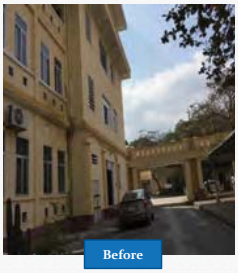
+ Evaluation. Fixing problems.

+ Revise the procedure if it is not appropriate

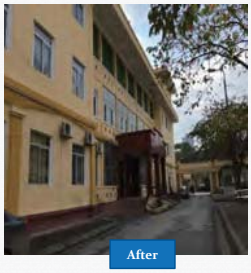
+ Maintain 5S activities

Actual state of hospital

Actual state of 5S implementation in the hospital



Before

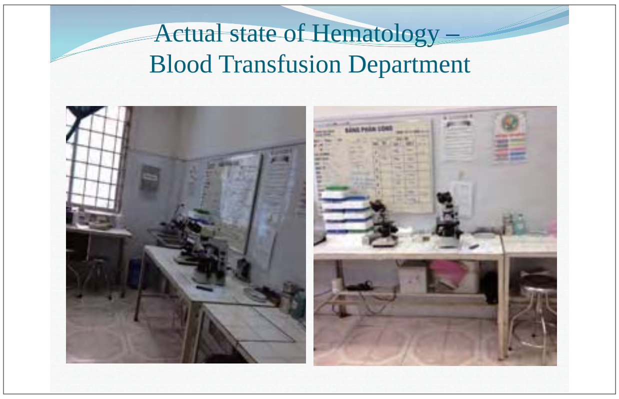


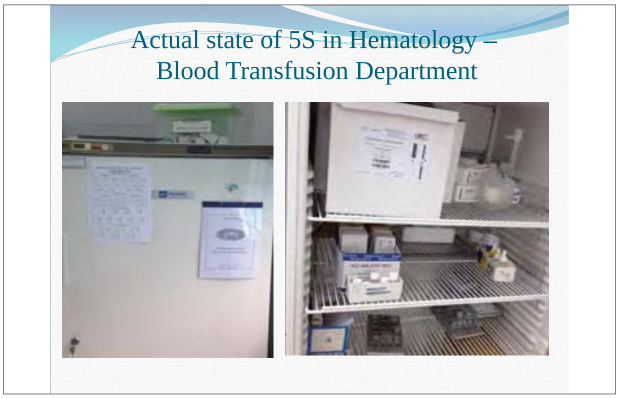
After

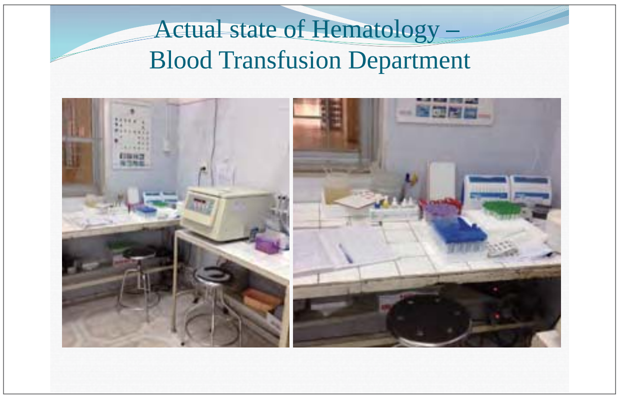
Actual state of hospital

Actual state of 5S implementation in 3 laboratories

Actual state of Hematology – Blood Transfusion Department


Actual state of Hematology –
Blood Transfusion Department


Actual state of 5S in Hematology –
Blood Transfusion Department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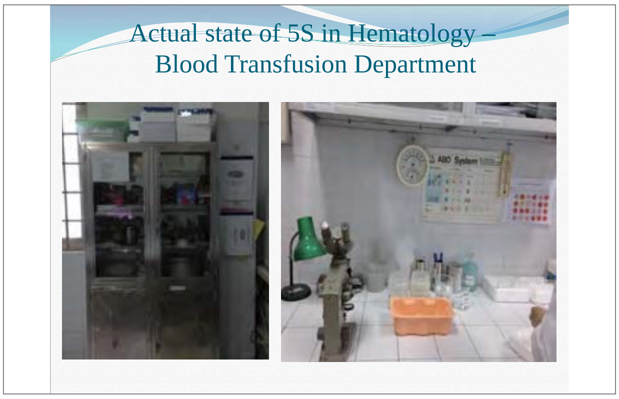
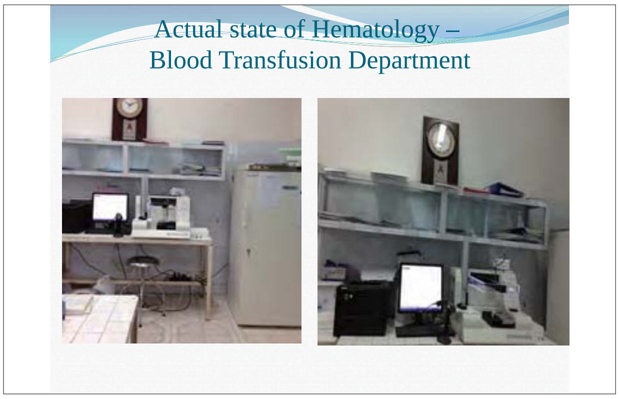
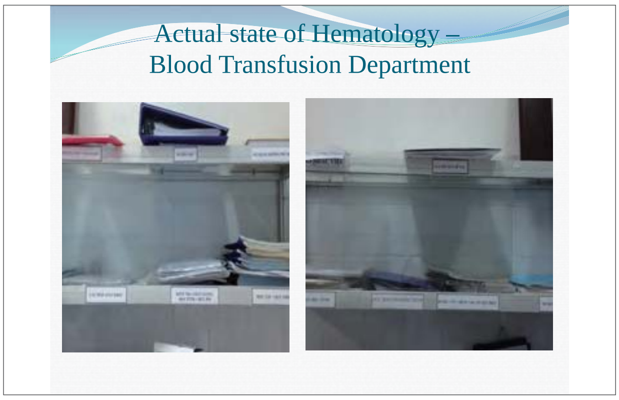
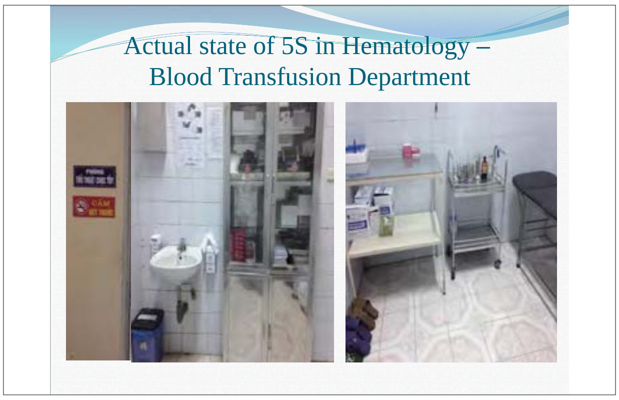

Actual state of 5S in Hematology –
Blood Transfusion Department


Actual state of Hematology –
Blood Transfusion Department


Actual state of 5S in Hematology –
Blood Transfusion Department


Actual state of Hematology –
Blood Transfusion Department


Actual state of 5S in Hematology –
Blood Transfusion Department

Actual state of 5S in Hematology – Blood Transfusion Department


Actual state of 5S in Microbiology Department


Actual state of 5S in Microbiology Department


Actual state of 5S in Microbiology Department


Actual state of 5S in Microbiology Department

Actual state of 5S in Microbiology Department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Actual state of 5S in Microbiology Department


Actual state of 5S in Biochemistry Department


Actual state of 5S in Microbiology Department

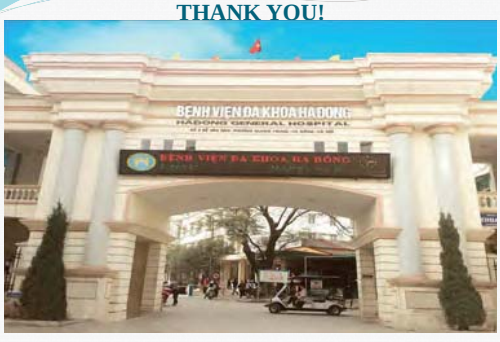

Actual state of 5S in Biochemistry Department


Actual state of 5S in Microbiology Department


Annex

Actual state of 5S in Biochemistry Department


THANK YOU!



Session 5-3

Plan for Implementing 5S in Thai Binh Provincial General Hospital

Tran Thi Quynh Anh

Quality Management Department, Thai Binh Provincial General Hospital

1. Reason for choosing the topic

To create a logical and comfortable working environment for hospital's staff and to create a clean and safe environment for examination, caring and treatment for patients is very important to our hospital's quality.

2. Actual state before 5S implementation

- Departments were not clean and tidy.
- Inappropriate arrangement of injection trolleys, drug cabinets, medical record store, etc.
- Many unnecessary things in departments.
- Toilets were dirty and untidy.

3. Objective

100% departments in the hospital implement 5S by 30 November 2016.

4. Action plan

4.1. Stage division:

- Stage 1: Pilot implementation

- Select 5 departments for pilot implementation: General Surgery Department, Endocrinology Department, Oncology Department, Pharmacy Department and General Planning Department)
- Duration: 03 months, from 01 March 2016 to 30 May 2016.

- Stage 2: Expansion

- Departments voluntarily register to implement 5S
- Duration: 03 months, from 01 June 2016 to 30 August 2016

- Stage 3: Comprehensive implementation

- Implementation in other departments
- Duration: 03 months, from 01 September 2016 to 30 November 2016

4.2. Activities:

STT	Time	Activities
1	Week 1	- Evaluate actual state of departments - Take pictures
2	Week 2	- 5S training
3	Week 3	- Group work with departments staff - Assign one person in charge of each area for 5S implementation
4	Week 4 to week 10	- Implement 5S in departments - Check, monitor and push implementation
5	Week 11 to week 12	- Evaluate implementation - Organize a workshop to present implementation results - Generate lessons learnt, improve and make next implementation plans.

THAI BINH DEPARTMENT OF HEALTH
PROVINCIAL GENERAL HOSPITAL

PROJECT FOR 5S IMPLEMENTATION

IN THAI BINH PROVINCIAL GENERAL HOSPITAL IN 2016

Dr. Tran Thi Quynh Anh, MD, 1st degree specialist
Vice chief of Quality Management Department
Email: tranthiquynhanh1980@gmail.com

THAI BINH PROVINCIAL GENERAL HOSPITAL AND QM ACTIVITIES

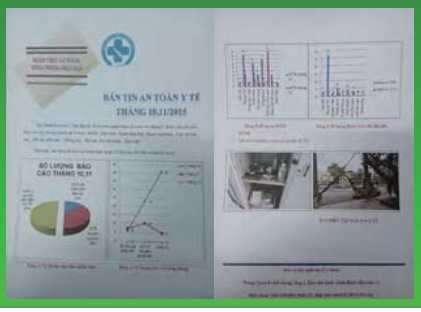
- Developing documents on PS:
  - Incident reporting form
  - Incident reporting procedure
  - Incident management procedure
  - Regulation on PS: regulations on correct patient identification, on drug usage, on handover among staff, on surgical safety, on fall prevention
  - PS bulletin board

THAI BINH PROVINCIAL GENERAL HOSPITAL AND QM ACTIVITIES

1st level hospital, the top level in Thai Binh province

+ Hospital's structure: 41 departments (23 clinical departments, 05 para-clinical departments, 13 functional departments)
+ Human resource: 919 staff (231 doctors, 450 nurses, 75 technicians, 35 pharmacists)
+ 1,000 planned beds; 1,180 actual beds
+ Bed occupancy rate: 178% planned beds; 105% actual beds

THAI BINH PROVINCIAL GENERAL HOSPITAL AND QM ACTIVITIES



THAI BINH PROVINCIAL GENERAL HOSPITAL AND QM ACTIVITIES

- The hospital QM system is quite complete, including:

* QM Council: 04 committees (of professional quality, infrastructure, manpower development and patient satisfaction)

* QMD: 06 staff (05 doctors, 01 nurse - 3 full-time staff and 03 part-time staff)

* QM network: 42 members

THAI BINH PROVINCIAL GENERAL HOSPITAL AND QM ACTIVITIES

- Patient satisfaction survey using MOH questionnaire
- Develop QI projects
- Implementing QI activities:
  - Improving waiting area in OPD
  - Install 50 cameras in emergency rooms to monitor patients
  - Install centralized oxygen supply system in 100% clinical departments
  - Install a queue machine in laboratory area

THAI BINH PROVINCIAL GENERAL HOSPITAL AND QM ACTIVITIES

- Incident reporting system:
  - Focal point for receiving and handling reports: QMD
  - RCA group : QMD, GPD, Nursing Department and relevant departments
  - Sources to collect incidents: voluntary reports, hospital meetings, medical records, monitoring in departments.
  - Reporting way: email, hospital server, direct report, telephone

5S PROJECT

1. REASONS FOR CHOOSING THE TOPIC

- To create a clean, tidy and convenient working and treatment environment.
- To reduce waste of time to concentrate on professional and patient care activities.
- To reduce incidents related to illogical working environment

5S PROJECT

2. OBJECTIVE

- 100% departments in the hospital implement 5S by 30 November 2016.

3. ACTUAL STATE BEFORE 5S IMPLEMENTATION

- Departments were not clean and tidy.
- Inappropriate arrangement of injection trolleys, drug cabinets, medical record store, etc.
- Many unnecessary things in departments.
- Toilets were dirty and untidy.

5S PROJECT

4. ACTION PLAN

4.1. Preparation stage

* Duration: 01 month (March 2016)

* Contents:

- Making plan
- Establishing a QI group to implement 5S
- Discussion
- Developing documents
- Preparing training materials…

5S PROJECT

3. ACTUAL STATE BEFORE 5S IMPLEMENTATION

5S PROJECT

4. ACTION PLAN

4.2. Implementation stage

Pilot implementation (03 months, from 01/4/2016 to 30/6/2016)	Expansion (03 months, from 01/7/2016 to 30/9/2016)	Comprehensive implementation (03 months, from 01/10/2016 to 30/12/2016)
Select 5 departments for pilot implementation: General Surgery Department, Endocrinology Department, Oncology Department, Pharmacy Department and GPD)	Departments voluntarily register to implement 5S	Implementation in other departments

5S PROJECT

3. ACTUAL STATE BEFORE 5S IMPLEMENTATION

5S PROJECT

5. Activities

STT	Time	Activities
1	Week 1	- Evaluate actual state of departments - Take pictures
2	Week 2	- 5S training
3	Week 3	- Group work with departments staff - Assign one person in charge of each area for 5S implementation
4	Week 4 to week 10	- Implement 5S in departments - Check, monitor and push implementation
5	Week 11 to week 12	- Evaluate implementation - Organize a workshop to present implementation results - Generate lessons learnt, improve and make next implementation plans.

5S PROJECT

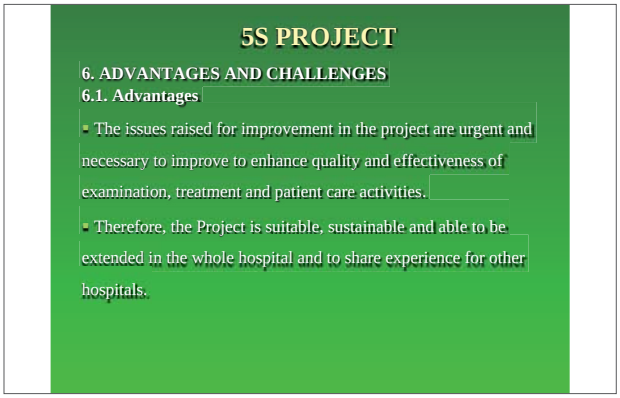
3. ACTUAL STATE BEFORE 5S IMPLEMENTATION

5S PROJECT

6. ADVANTAGES AND CHALLENGES

6.1. Advantages

- Hospital leaders always care and give direction to all QI activities, especially 5S implementation.
- Members of QM system and staff of QMD are very enthusiastic.
- QI activities in the hospital are receiving collaboration and agreement of healthcare workers.
- The hospital has a budget for 5S activities from the Norred project.


5S PROJECT
6. ADVANTAGES AND CHALLENGES
6.1. Advantages
▪ The issues raised for improvement in the project are urgent and necessary to improve to enhance quality and effectiveness of examination, treatment and patient care activities.
▪ Therefore, the Project is suitable, sustainable and able to be extended in the whole hospital and to share experience for other hospitals.


5S PROJECT
6. ADVANTAGES AND CHALLENGES
6.2. CHALLENGES
- Expectation from hospital leaders
- Manpower
- Working habit
- Maintaining 5S

Session 5-4

WHO IS CUSTOMER?
5S

Megumi Ikarashi

Bureau of International Health Cooperation, NCGM, Japan

Who is customer?
5S

What we should think about 5S in healthcare institutes?

First and foremost, enhancing professional efficiency and preventing medical incidents.

It is important to connect this enhancement with increasing patient satisfaction.

Furthermore, in order to do this, organizational management capacity is needed.

5S is easy to understand.

But…

5S is not easy to implement.

Who is customer?

What is 5S?

- **Sort**
  - Sort disorganized items.
- **Straighten**
  - Clean and organize items and rooms neatly.
- **Shine**
  - Clean up regularly and ensure that the environment is free from garbage and dust.
- **Standardize**
  - Maintain cleanliness by strictly follow and revisit 3S: Sort, Straighten, Shine.
- **Sustain**
  - Create habits of complying to developed regulations. = Training.

Who is customer?

Who is customer?

Who is customer?

Who is customer?

Let's try to implement 5S
at office, department, your desk...

"Shitsuke" = **S**ustain

Session 6-1

Reducing Ventilator Associated Pneumonia by 5% and Pressure Ulcer by 10% in ICU within 3 months

Tran Quang Dat

ICU, Quality Management Department, Quang Nam Central General Hospital

1. Reasons for improvement activity

Ventilator associated pneumonia (VAP) is the pneumonia that occurs after 48 or more hours of hospital admission in patients who are not in incubation period nor acquired at admission. This is a common healthcare associated infection in Intensive Care Unit (ICU) and a leading cause of mortality (30–70%) among nosocomial infections, prolonging hospital stay and increasing treatment costs.

In Viet Nam, a national survey over 19 hospitals in 2005 showed that VAP rates were especially high in patients in ICU (43-63.5/1,000 days of mechanical ventilation). Hospital acquired pneumonia is a leading cause of mortality among nosocomial infections (30-70%), prolonging hospital stay to 6-13 more days and increasing costs from 15 to 23 million VND for one case.

In our hospital in 2015, the number of patients with VAP was large (36%), which is not improving. In ICU, the risk of pressure ulcer for patients was also high, which was a cause of increased mortality and treatment costs and longer hospital stay. Therefore, we conduct improvement activity to reduce the rate of VAP and pressure ulcer in ICU.

2. Action plan: starting from February 2016

Establishing an improvement group

Surveying the rates of VAP (the number of pneumonia patients/1,000 days of mechanical ventilation) and bedsore (the number of pressure ulcer patients/1,000 days of hospital stay).

Analyzing root causes and proposing improvement solutions.

Re-surveying the rates of VAP and bedsore after 3 months of improvement.

3. Objective

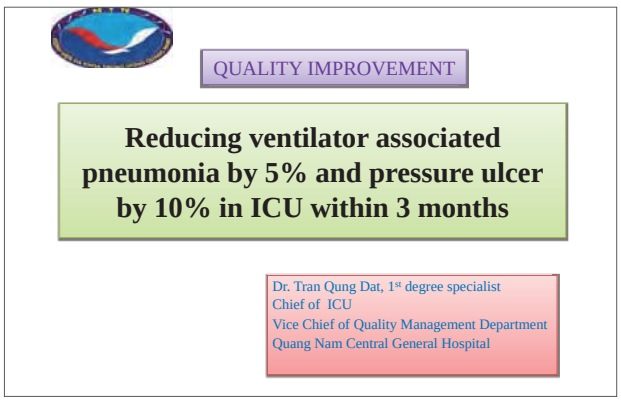
100% departments in the hospital implement 5S by 30 November 2016.

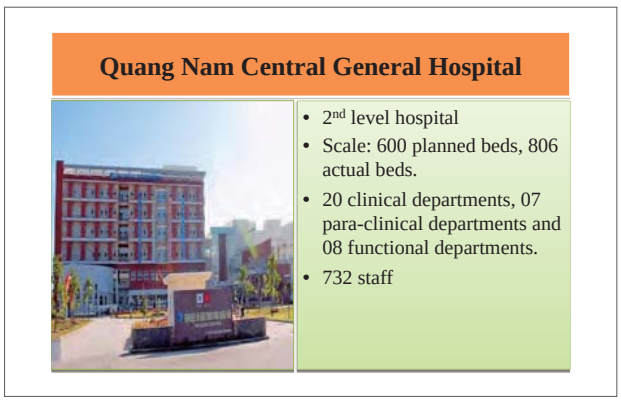
3_a. Current state

The VAP rate in ICU in our hospital in 2015 was 36%.

3_b. Targets for achievement

The rate of VAP in ICU in 2016 is reduced by 5% and that of bedsore by 10% after 3 months of improvement.





QMD

There are 6 members
- Chief : Vice director (part-time)
- Vice chief : chief of ICU (part-time)
- Vice chief : a college nurse
- 1 doctor
- 1 bachelor of hospital management
- 1 nurse

REASONS FOR IMPROVEMENT ACTIVITY

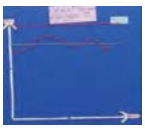
- Ventilator associated pneumonia (VAP) is the pneumonia that occurs after 48 or more hours of hospital admission in patients
- This is a common healthcare associated infection in ICU.
- n Viet Nam, a national survey over 19 hospitals in 2005 showed that VAP rates were especially high in patients in ICU (43-63.5/1,000 days of mechanical ventilation).
- Hospital acquired pneumonia is a leading cause of mortality among nosocomial infections (30 -70%), prolonging hospital stay to 6-13 more days and increasing costs from 15 to 23 million VND for one case.

QMD'S MAJOR ACTIVITIES

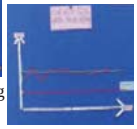
Receiving and handling medical incidents

Conduct roots cause analysis

Implementing 5S



Quality indicators



Developing and measuring quality indicators

REASONS FOR IMPROVEMENT ACTIVITY

- In our hospital in 2015, the number of patients with VAP was large (36%), which is not improving.
- In ICU, the risk of pressure ulcer for patients was also high, which was a cause of increased mortality and treatment costs and longer hospital stay.
- Therefore, we conduct improvement activity to reduce the rate of VAP and pressure ulcer in ICU.

Organizing trainings on PS

Training, sharing information

Monthly QM network meetings

OBJECTIVES

- Reducing VAP by 5% within 3 months.
- Reducing bedsore by 10% within 3 months.

ICU:
25 beds
5 doctors
22 nurses

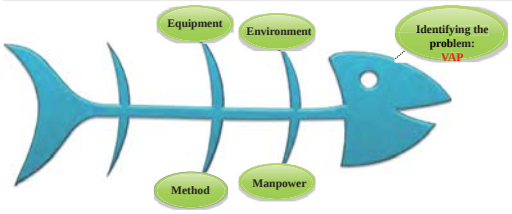
Nurses are divided into 3 shifts (each shift has 4 nurses), 4 groups.

ACTION PLAN

No.	Activities	Time	In charge
1	Establishing an improvement group		
2	Surveying the rates of VAP per 1,000 days of mechanical ventilation and bedsore per 1,000 days of hospital stay	1 month	Improvement group
3	Analyzing root causes and proposing improvement solutions	2 weeks	Improvement group and doctors in ICU
4	Training and implementing solutions	2 weeks	Dr. Dat and improvement group
5	Re-surveying the rates of VAP and bedsore	After 1, 2, 3 months of interventions	Improvement group

CAUSE ANALYSIS

Focus on infection factors



CAUSE ANALYSIS FOR PNEUMONIA

Employing fishbone diagram and 5 WHY, we identified some following causes:

- Nurses did not follow the procedure for taking care of patients with mechanical ventilation.
- Lack of devices such as: tracheal tube, bag mask, cuffed tracheal tube…
- Cleaners: no procedure for treatment of ventilator after use
- Environment of ICU was not treated regularly.

PROPOSED IMPROVEMENT MEASURES

- Retraining for old and new nurses and trainees in the department on mechanical ventilation procedure.
- Strengthening monitoring to ensure that nurses follow the procedures properly.
- Buying more devices: sterilized tracheal tube, bag mask, etc.
- Developing procedures for treatment of ventilator after use.
- Developing collaboration procedure: Infection Control Department, ICU and Administrative Department.

CAUSE ANALYSIS FOR BEDSORE

Causes are related to nursing care.

- Nurses did not follow properly procedures for bedsore prevention.
- Lack of bedsore prevention devices.
- Patient's nutrition status was not assessed fully for intervention.

PROPOSED IMPROVEMENT MEASURES

- Developing, training and monitoring implementation of bedsore prevention procedures for nurses.
- Using more bedsore prevention devices, especially for high-risk patients.
- Conducting nutrition assessment and providing proper interventions.

POST-INTERVENTION EVALUATION

- Post-intervention evaluation: VAP and bedsore have been improved compared with at the time of survey.
- Causes of remaining problems are identified for further improvement.

CHALLENGES

- The number of patients with mechanical ventilation per month is small → data might be inaccurate.
- Buying more equipment → more costs.

Session 6-2

Antimicrobial Stewardship Program Helps Increase the Rate of Proper Use of Prophylactic Antibiotics in Surgery from 65% to 75% after One PDCA Cycle

Ton Thanh Tra

Quality Management Department, Cho Ray Hospital

1. Introduction

Overuse of antibiotics, especially in operation patients, is common in developing countries like Viet Nam. This is one of the reasons leading to increased treatment costs and antimicrobial resistance, especially in top level hospitals. On World Health Day on 7 April 2011, World Health Organization called to combat antimicrobial resistance with the motto "No action today, no cure tomorrow". In this context, Cho Ray Hospital started an antimicrobial stewardship (AMS) program in 2012. After collecting microbiological data, developing guidelines for and trainings on antibiotics use, the AMS program started in 2015. However, monitoring results show that the rate of proper use of prophylactic antibiotics in surgery (clean and clean-contaminated) only accounted for 65%.

Objective: The rate of proper use of prophylactic antibiotics in surgery increases from 65% to 75% after one PDCA cycle.

2. Activities

- Organizing trainings on proper use of prophylactic antibiotics in surgery for all surgeons.
- Releasing announcement of guidelines on using prophylactic antibiotics in surgery.
- Organizing a group to monitor antibiotics prescription in daily operation approval.
- Evaluating and reporting monitoring results at the end of each month.

3. Results

After implementing different solutions, the rate of proper use of prophylactic antibiotics in patients with clean or clean-contaminated surgeries increased from 65% to 79% after one PDCA cycle. Besides, surgical site infection (SSI) risk stratification was conducted over 100% planned surgeries. However, 80% patients were indicated antibiotics after surgery without evidence of infection.

4. Cause analysis

- Surgeons have increased awareness on antibiotics use.
- Monitoring activities seem effective.
- Setting objectives to gradually improve after PDCA cycles.
- Regulation is clear about reward and punishment.

Why is surgeons' compliance rate not high?

- They are too busy to care.
- The longtime habit of using antibiotics after surgery is difficult to change.
- They are not highly aware of antimicrobial resistance.
- They lack trust in infection control and hospital environment.
- Not enough evidence to convince surgeons not to use antibiotics after surgery.
- There may be other causes.

5. Next plan

- Strengthening infection control
- Studying SSI rates, comparing compliant group and non-compliant group
- Strengthening monitoring activities
- Organizing meetings to review antibiotics indication in medical records
- Setting objective for a new PDCA cycle (80%) in the

next 2 months and the rate of improper use of antibiotics after surgery reduces from 80% to 50%.

6. Conclusion

Applying PDCA cycle to improve quality in AMS seems easy to understand, easy to implement and to bring effectiveness. Setting short-term objectives, developing a detailed action plan, evaluating the outputs and analyzing causes in one cycle help make plan for the next.

INCREASING THE RATE OF PROPER USE OF PROPHYLACTIC ANTIBIOTICS IN SURGERY FROM 65% TO 75% AFTER ONE PDCA CYCLE

Dr. Ton Thanh Tra, MD., MSc.
Quality Management Department
Cho Ray Hospital, Ho Chi Minh City, Viet Nam

Cho Ray Hospital

- Overloaded
- Sometimes 2 surgeries take place at the same time in one operating room
- Indicating antibiotics after surgery is common

PRESENTATION CONTENTS

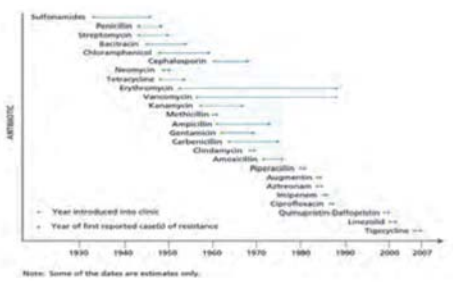
- Context
- Developing quality objectives in PDCA cycle
- Introduction of AMS program
- Lessons learnt
- Conclusions

Cho Ray Hospital

- Special level general hospital
- 120-150 surgeries per day
- > 200 surgeons
- Surgeons are able to perform more than 2 surgeries per day

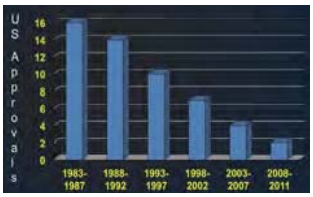
ANTIMICROBIAL RESISTANCE OCCURS RAPIDLY

Antimicrobial resistance may make infections incurable



ANTIMICROBIAL RESOURCES BECOME MORE AND MORE LIMITED

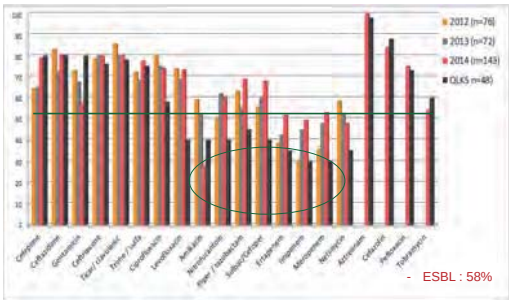
– Bacteria resist better over time
– Irrational antibiotics use
– Not many new types of antibiotics



The numbers of FDA-approved antibiotics

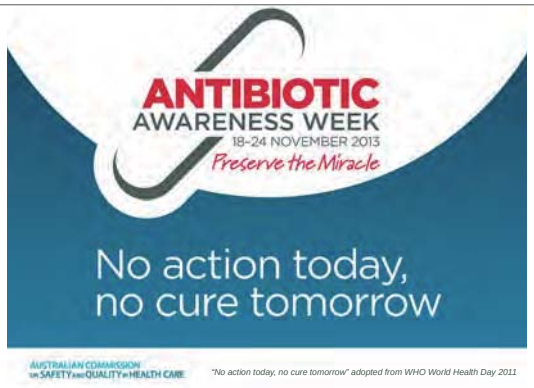
www.idsociety.org

RESISTANCE SITUATION OF *K.PNEUMONIAE*



- **Most of antibiotics are resisted by > 50%**
- **Amikacin; Netimycin, carbapenem : 35 %**

TTTNGA CLINICAL MICROBIOLOGY CHORAY HOSPITAL

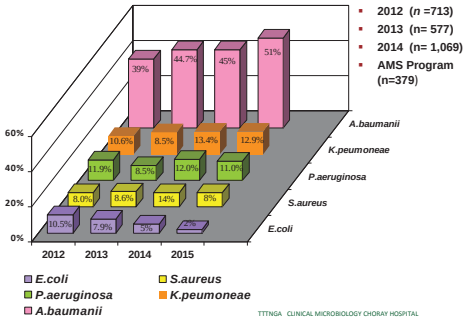


"No action today, no cure tomorrow" adopted from WHO World Health Day 2011

AMS PROGRAM

- Guideline for antibiotic use was developed in 2010 and updated in 2013.
- Trainings were conducted in 2013-2014
- Monitoring from June 2014 to present.
- Pilot implementation in 6 clinical departments: Respiratory Internal Medicine Department, ICU, Tropical Diseases Department, Urology Surgery Department, Gastroenterology Surgery Department and Hepatology Surgery Department.

5 PATHOGENIC BACTERIA

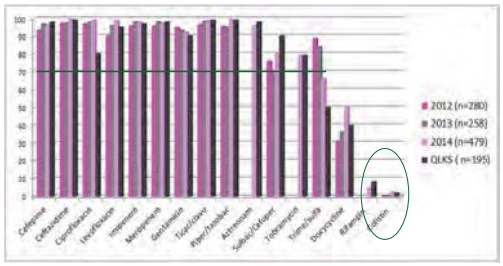


TTTNGA CLINICAL MICROBIOLOGY CHORAY HOSPITAL

INTRODUCTION OF AMS PROGRAM

- Clinical pharmacists in collaboration with clinical doctors study medical records with antibiotics indication for inpatients in pilot departments
- Organizing monthly meetings

RESISTANCE SITUATION OF *A.BAUMANNII*



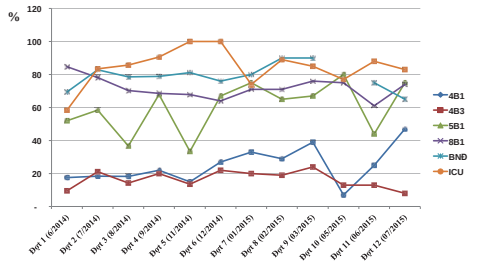
- **Most of antibiotics are resisted by > 70%**
- **Doxycline < 35% Rifampin< 10% Colistin <5%**

TTTNGA CLINICAL MICROBIOLOGY CHORAY HOSPITAL

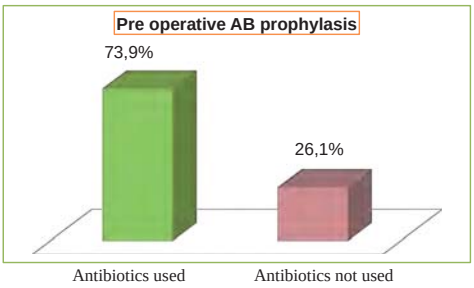
NUMBERS OF SPECIMENS

Wards	Batch 1-4 (9/2014)	Batch 5 (11/2014)	Batch 6 (12/2014)	Batch 7 (01/2015)	Batch 8 (02/2015)	Batch 9 (03/2015)	Batch 10 (05/2015)	Batch 11 (06/2015)	Batch 12 (07/2015)	Total
4B1	101	40	15	36	35	28	14	12	17	298
4B3	110	37	18	20	49	25	15	31	36	341
5B1	107	42	29	24	29	24	20	16	8	299
8B1	118	31	28	14	42	37	16	36	38	360
BND	91	37	29	25	20	20		28	37	287
ICU	76	26	23	23	18	34	13	32	18	263
Total	603	213	142	142	193	168	78	155	154	1,848

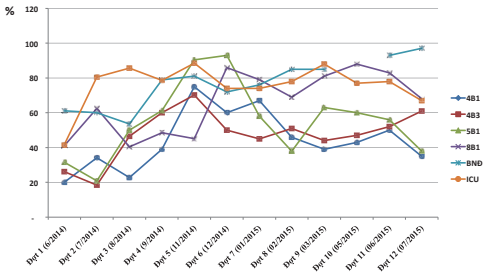
THE RATES OF SENDING SPECIMEN FOR CULTURE BEFORE INDICATING ANTIBIOTICS



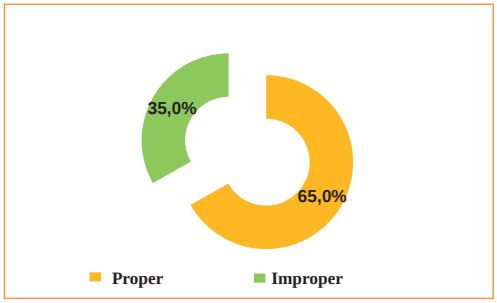
PRE-OPERATIVE ANTIBIOTICS USE



THE RATES OF CHOOSING THE FIRST ANTIBIOTICS FOLLOWING THE HOSPITAL'S GUIDELINE

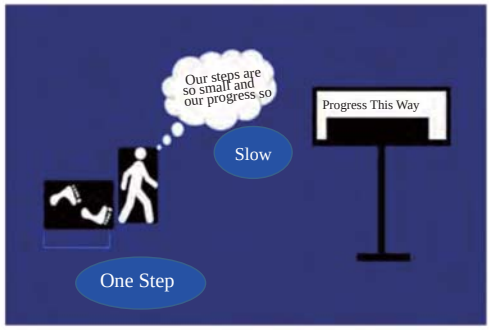


RATE OF PROPER USE

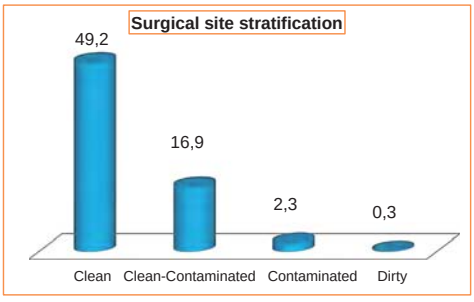


PROPHYLACTIC ANTIBIOTICS

Department	Total number of medical records
3B1	26
3B3	31
4B1	63
4B3	17
5B1	53
5B3	18
Total number of medical records	208



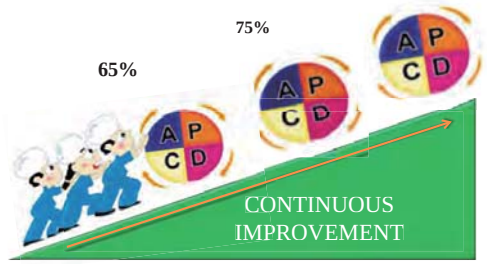
SSI RISK STRATIFICATION



INTERVENTIONS

- Organizing a group to monitor antibiotics prescription in daily operation approval.
- Evaluating and reporting monitoring results at the end of each month.

PDCA CYCLE



PRE-OPERATIVE PROPHYLACTIC ANTIBIOTICS USE

	Number of medical record	Clean	Clean-contaminated
4B1	134	37	27
4B3	44	24	10
5B1	120	59	31
Total	**298**	**120**	**68**

OBJECTIVE

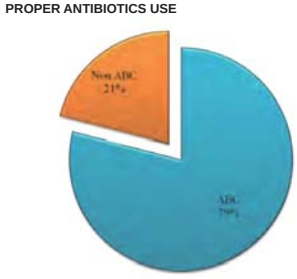
The rate of proper use of prophylactic antibiotics in surgery increases from 65% to 75% after one PDCA cycle.

RESULTS

- SSI risk stratification was conducted over 100% planned surgeries.
- 188/298 (63%) surgeries were clean or clean-contaminated
- Compliance rate to guideline on antibiotics use was 79%

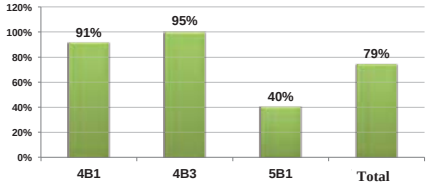
INTERVENTIONS

- Organizing trainings on proper use of prophylactic antibiotics in surgery for all surgeons.
- Releasing announcement of guideline on using prophylactic antibiotics in surgery.



PRE-OPERATIVE ANTIBIOTICS USE

Following hospital's guideline



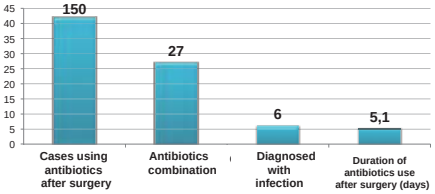
Most cases used only 1 kind of antibiotics. Only one case was indicated 2 kinds of antibiotics (Meronem + Tinidazole) due to being diagnosed with pneumonia/ diabetes type 2

In general, surgery approval and preoperative antibiotic use have been improved much, without any medical records showing long use of antibiotics before surgery.

WHY SURGEONS DID NOT COMPLY?

- Too busy to concern.
- Longtime habit of using antibiotics after surgery is difficult to change
- Not fully aware of antimicrobial resistance situation

POST-OPERATIVE ANTIBIOTICS USE DURATION OF ANTIBIOTICS USE AND ANTIBIOTICS COMBINATION



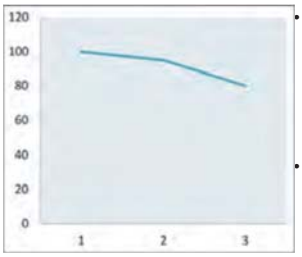
Antibiotics were indicated after surgery without diagnosis of infection:

- *150 cases (80%) continued to use antibiotics after surgery*
- *27 cases combined 2 kinds of antibiotics*

WHY SURGEONS DID NOT COMPLY?

- Lack trust in infection control and hospital environment
- Not enough evidence to convince surgeons not to use post-operative antibiotics
- There may be other reasons

POST-OPERATIVE ANTIBIOTICS USE



- Although pre-operative antibiotics use has improved, antibiotics are still indicated after surgery, mainly because the operations were significant and long.
- Many medical records did not include the reasons for antibiotics indication.

NEXT PLAN

- Strengthening infection control
- Studying SSI rates, comparing compliant group and non-compliant group
- Strengthening monitoring activities and IT application

CAUSE ANALYSIS

- Strong direction from the directing board
- Close monitoring
- Clear objectives
- Specific interventions
- Combine different ways of monitoring

IT APPLICATION

APPLICATION ON SMARTPHONE

Conclusions

- Applying PDCA cycle to AMS seems to be effective
- Set clear and feasible short-term objectives
- After one PDCA cycle, analyze results, generate lessons learnt and set objectives for the next cycle.

THANK YOU AND ENJOY YOUR TIME
HAPPY NEW YEAR 2016

WELCOME TO VIETNAM FORUM ON QUALITY MANAGEMENT AND PATIENT SAFETY 2016

Dr. Ton Thanh Tra, MD., MSc.
Quality Management Department
Cho Ray Hospital


VỆ SINH
Toilet

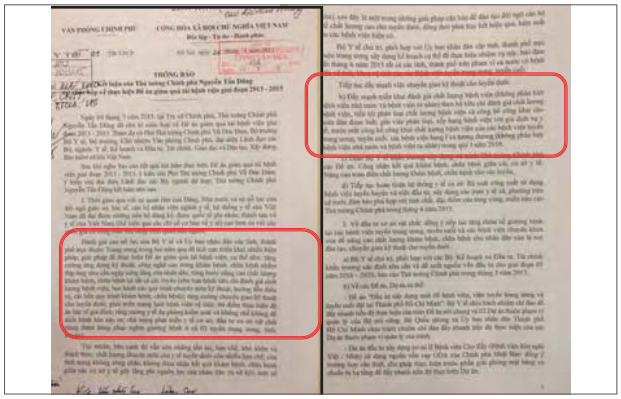

BỆNH VIỆN ĐA KHOA
TỈNH NINH BÌNH

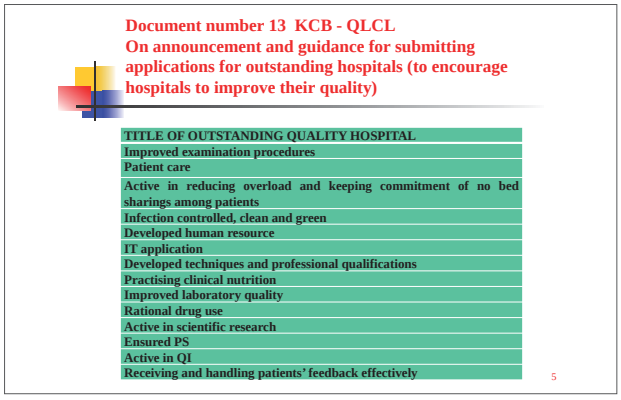
Session 7

Applying Hospital Quality Standards to Improve Hospital Quality and Patient Care

Duong Huy Luong

Vice chief of QMD, Medical Services Administration, MOH





- **NATIONAL ACTION PROGRAM (NAP) TO IMPROVE QM CAPACITY TILL 2025**
- (Issued with Decision number 4276/QD-BYT dated 4 October 2015 by the Minister of Health)

7

NAP'S SPECIFIC OBJECTIVES

1. To develop and complete legal framework, policy and organizing system to strengthen QM;
2. To develop and issue quality standards and tools to evaluate and measure services quality of healthcare institutions, healthcare practitioners and professional qualifications;
3. To promote application of QM methods and implementation of interventional programs to enhance QM capacity;
4. To enhance awareness of QM in healthcare, gradually developing quality culture in healthcare institutions;

TENTATIVE ACTIVITIES

Reaching objective 1. To develop and complete legal framework, policy and organizing system to strengthen QM

1.1. Develop, issue and monitor implementation of legal documents related to healthcare services quality.

- Circular guiding management of medical incidents
- Hospital quality standards (HQS)
- Medical services quality standards for communal health centers

1.2. Develop policies to encourage improve quality of healthcare institutions and healthcare practitioners

- Promote and facilitate the establishment of a healthcare accreditation organization
- Update and adjust regulations on granting practising certificates and assessing professional qualifications and ethics.

TENTATIVE ACTIVITIES

1. **To develop and complete legal framework, policy and organizing system to strengthen QM**

1.3. Establish QM system within healthcare system

- In MOH: Establish Healthcare Services Quality Council
- In DOH: appoint staff to take charge of QM activities. QM Council is recommended; Develop and approve provincial action program for QM in healthcare
- In hospitals: establish Hospital QM Council to run activities. Establish QM department/unit, QM network and appoint full-time staff to take charge of QM.

TENTATIVE ACTIVITIES

Reaching objective 2: To develop and issue quality standards and tools to evaluate and measure services quality of healthcare institutions, healthcare practitioners and professional qualifications

2.1. Develop HQS and quality standards for other healthcare institutions.

2.2. Develop competency standards for practitioners: General doctors, specialized doctors, technicians, midwives.

2.3. Develop some specialized quality standard sets for: nursing care, infection control, reproductive health, etc.

TENTATIVE ACTIVITIES

2.4. Develop, conduct a pilot, evaluate and release the HQS.

2.5. Develop the lists of common diseases, emergency diseases, chronic diseases, high-tech services accounting for 80% of inpatient and outpatient treatment costs.

2.6. Develop, update and issue guidelines for diagnosis and treatment, technical procedures, nursing care, and professional procedures in accordance with the above lists (2.5).

2.7. Update the above guidelines every 2 years. Develop technical guidelines for diseases, techniques accounting for 80% of inpatient and outpatient treatment costs.

2.8. Survey satisfaction of patients and healthcare workers.

2.9. Develop database on manpower, finance and professional activities of healthcare institutions and software supporting doctors in examination and treatment

TENTATIVE ACTIVITIES

Reaching objective 3: To promote application of QM methods and implementation of interventional programs to enhance QM capacity

3.1. Support hospitals to develop plans/projects and apply QM methods

3.2. Develop and approve materials for QM continuing education.

3.3. Conduct QM training courses for in-charge staff and quality evaluators.

3.4. Develop and implement measurement projects and release the HQS.

TENTATIVE ACTIVITIES

3.5. Create quality rewards for healthcare institutions;

3.6. Implement national QI programs in: nursing care, clinical nutrition, infection control, rational drug use, voluntary incident reporting system.

3.7. Develop and implement some clinical accreditation programs in some specialties, common diseases and chronic diseases.

3.8. Develop a pilot project for healthcare technology evaluation.

TENTATIVE ACTIVITIES

Reaching objective 4. To enhance awareness of QM in healthcare, gradually developing quality culture in healthcare institutions

4.1. Develop and implement communication projects to raise awareness of healthcare quality for healthcare managers, hospital leaders, healthcare institutions and practitioners;

4.2. Develop and implement communication projects to raise awareness of healthcare quality, rights and responsibilities in healthcare services for patients and community.

TENTATIVE ACTIVITIES

4.3. Introduce and disseminate quality initiatives. Make plans and organize study visits to healthcare institutions that are successful in QM in the country.

4.4. Organize regular workshops and forums on hospital QM to share information, models and QI initiatives of some hospitals to others.

4.5. Vote for and award annual hospital quality prize.

DRAFT LIST OF NEW ADDITIONAL CRITERIA IN 2016

Clinical quality

1. Developing general disease patterns of hospital and clinical departments.
2. Monitoring and evaluating clinical quality based on disease patterns.
3. Following the technical list by hospital level.
4. Studying and applying new techniques and methods.
5. Applying and developing technical procedures for healthcare services and monitoring quality

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6. Developing diagnosis and treatment guidelines
7. Applying diagnosis and treatment guidelines
8. Monitoring compliance to diagnosis and treatment guidelines
9. Developing and computerizing treatment protocols to improve clinical quality
10. Developing, evaluating and improving clinical quality indicators
11. Conducting clinical accreditation and QI

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Nurses

- Technical procedures for nurses, midwives and technicians are standardized
- When patients are admitted to hospital, nurses check patients' condition, assess nursing care needs and monitor
- Nurses support patients to use drugs following indications to ensure safety and effectiveness.
- Nurses assess patients' pain level and provide them palliative care

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Laboratory

1. Checking with clinical examination and pathology
2. Ensuring pre-test quality
3. Ensuring quality during test period
4. Ensuring post-test quality

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Scientific research and training

- Implementing training tasks

Towards patients

- Patients benefit from charity programs and social work
- Directing healthcare activities to other levels

Towards healthcare workers

- Surveying healthcare workers' satisfaction.

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Patient safety

- Ensuring safety in blood preservation and blood transfusion in hospital.
- Ensuring safety in clinical blood transfusion.
- Applying surgical safety checklist
- Ensuring correct patient identification
- Ensuring safety in information exchange between healthcare workers and patients
- Managing and utilizing medical equipment safely and effectively
- Safe radiation during diagnosis and treatment

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Preventive medicine and communicable diseases

- Ensuring safe immunization
- Ensured capacity for receiving, diagnosing and treating communicable diseases
- Facilities are good enough for treatment of common communicable diseases
- Developing and applying diagnosis and treatment guidelines for common communicable diseases in hospital.
- Reporting and monitoring communicable diseases following current regulations.
- Organizing outpatient examination for HIV/AIDS and treatment by technical level

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Patient satisfaction

- An important criterion to evaluate the hospital's prestige and services quality.
- A measure reflecting the outcomes of public and private healthcare institutions.

Final goal of hospitals

PATIENT SATISFACTION

Obstetrics

- Developing systems for reporting and collecting data of 5 obstetric complications, including those leading to maternal mortality.
- Utilizing prophylactic antibiotics in obstetric and gynecologic operations and procedures
- Controlling appropriate rates of Caesarian section
- Capacity of pregnancy management system
- Capacity to care for newborns and premature babies

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Healthcare workers' satisfaction

Human resource: THE MOST IMPORTANT RESOURCE

Evaluating staff's satisfaction is a significant factor that can help improve the hospital's healthcare services quality.

increasing patient satisfaction

ESTABLISHMENT OF PATIENT FEEDBACK SYSTEM

- 1. Patient satisfaction form
- 2. Abnormal incidents rapid reporting form
- 3. Opinion box to receive patients' feedback, including 2 forms:
  - Thank-you form
  - Complaint form

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ORIENTATION FOR SURVEYING PATIENT SATISFACTION

- Patient and healthcare worker satisfaction surveys become routine work.
- Applying IT to survey
- Do not print out forms, fill them directly with tablets and smartphones (Iphone, Ipad, Android)
- Saving thousands of tons of paper and working days for inputting data and analyzing results.
- Hospitals access the website WWW.KCB.VN and input information online (AVAILABLE ON KCB.VN)

HOSPITALS SURVEY SATISFACTION OF PATIENTS AND HEALTHCARE WORKERS

- Survey toolset was issued with Decision number 1334/QD-BYT dated 6 November 2015
- Hospitals survey by themselves and the evaluation team conducts an independent survey and compares with hospital's results when evaluating hospital quality

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THANK YOU VERY MUCH AND WISH ALL PARTICIPANTS HAVE EXCITING AND FRUITFUL DISCUSSIONS!

Dr.Luong.kcb@gmail.com

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Forum Outline

Vietnam Forum on Quality Management and Patient Safety 2016

19-21 January 2016

Ex-participants of the training course on
Quality Management and Patient Safety in Japan in 2015
Bach Mai Hospital
Ninh Binh Provincial General Hospital

Program for International Promotion of Japan's Healthcare Technologies and Services
Strengthening Healthcare Staff's Capability of Quality Management in Healthcare in Viet Nam

Objectives:

1. Sharing experiences of plans and progresses of small changes in quality management and patient safety (QM/PS) among hospitals in Vietnam;
2. Enhancing communication among people interested in QM/PS.

Program:

1. **Hospital Tour**

   Place: Ninh Binh Provincial General Hospital

   Date: 19th January 2016

2. **Forum: Presentations and discussion**

   Place: Bach Mai Hospital

   Date: 20th - 21st January 2016

Participants:

- Presenters are graduates from the training courses on QM/PS organized at National Center for Global Health and Medicine (NCGM), Japan
- Observers are people who are interested in planning and action to create small changes in hospitals in Vietnam.

The Forum was funded by the Program for International Promotion of Japan's Healthcare Technologies and Services, FY2015, and implemented by NCGM and Japan's Ministry of Health, Labor and Welfare.

Program

Program 20/01/2016	
08:00 - 08:30	Reception
08:30 - 08:35	Opening speech
08:35 - 08:50	Objectives of the forum
Session 1	**Learning culture in hospital**
08:50 - 09:30	**Challenges in shifting from punishment culture to learning culture to improve patient safety** *Dr. Le Viet Nho,* *Vice Director, Head of Quality Management Department, Quang Nam Central General Hospital*
Session 2	**Establishing incident reporting system in hospital**
09:35 - 10:15	**Establishment of medical incident management system in Bach Mai Hospital** *Dr. Nguyen Thi Huong Giang,* *Head of Quality Management Department, Bach Mai Hospital*
10:15 - 10:30	Tea break
10:30 - 11:10	**Developing incident reporting system in Ha Nam Provincial General Hospital** *Dr. Phan Anh Phong,* *Vice Director, Ha Nam Provincial General Hospital*
11:15 - 11:55	Discussion
12:00 - 13:30	Lunch
Session 3	**Improving compliance to timing standard**
13:30 - 14:10	**Improving compliance to standard emergency response time from 55% to 85% in December 2016** *Dr. Pham Viet Thai,* *Head of Quality Management Department, Ninh Thuan Provincial General Hospital*
14:10 - 15:30	Tea break
Discussion	
14:30 - 15:10	**Eight core values in quality management in Japan** *Dr. Shinsuke Murai,* *National Center for Global Health and Medicine, Japan*
15:10 - 16:00	Discussion

Program 21/01/2016	
Session 4	**Improving service quality in OPD**
08:50 - 09:10	**Plan to improve management and medical safety in dispensing drugs to patients in Outpatient Department** *Dr. Tran Quang Hien,* *Director, An Giang Hospital of Obstetrics, Gynecology and Pediatrics*
Session 5	**5S**
09:15 - 9:55	**5S implementation in two departments in Ninh Binh Provincial General Hospital (Nephro-urological Surgery and Endocrinology Departments)** *Dr. Vu Thuy Giang,* *Head of Quality Management Department, Ninh Binh Provincial General Hospital*
09:55 - 10:10	Tea break
10:10 - 10:50	**5S implementation in Ha Dong General Hospital** *Dr. Nguyen Thi Huong Lien,* *Head of Quality Management, Dong General Hospital*
10:55 - 11:35	**Project for 5S implementation in Thai Binh Provincial General Hospital** *Dr. Tran Thi Quynh Anh,* *Deputy Head of Quality Management Department, Thai Binh Provincial General Hospital*
11:40 - 13:30	Lunch
13:35 - 14:00	**5S** *Ms. Megumi Ikarashi, Bureau of Medical International Cooperation,* *National Center for Global Health and Medicine, Japan*
Session 6	**Improving quality in clinical departments**
14:00 - 14:40	**Reducing ventilator associated pneumonia by 5% and pressure ulcer by 10% in ICU within three months** *Dr. Tran Quang Dat,* *Deputy Head of Quality Management Department, Quang Nam Central General Hospital*
14:45 - 15:25	**Increasing the rate of proper use of prophylactic antibiotics in surgery after one PDCA cycle** *Dr. Ton Thanh Tra,* *Head of Quality Management Department, Cho Ray Hospital*
15:25 - 15:30	Tea break
Session 7	**Updates from the Ministry of Health**
15:30 - 16:00	**Applying Hospital Quality Standards to improve hospital quality and patient care** *Dr. Duong Huy Luong,* *Medical Services Administration, Vietnam Ministry of Health*
16:00 - 16:25	Discussion
16:25 - 16:30	Closing

Steering Committee

1. Hospital Tour (19 January 2016)

Ninh Binh Provincial General Hospital

Dr. Vu Thuy Giang, M.D., MSc.

2. Presentations (20-21 January 2016)

Dr. Nguyen Thi Huong Giang, M.D., MSc.

Dr. Le Viet Nho, M.D., PhD.

Dr. Phan Anh Phong, M.D., MSc.

Dr. Pham Viet Thai, M.D.

Dr. Shinsuke Murai, DDS., PhD.

Dr. Tran Quang Hien, M.D., PhD.

Dr. Vu Thuy Giang, M.D., MSc.

Dr. Nguyen Thi Huong Lien, M.D., MSc., 2nd Degree Specialist

Dr. Tran Thi Quynh Anh, M.D., 1st Degree Specialist

Dr. Tran Quang Dat, M.D., 2nd Degree Specialist

Dr. Ton Thanh Tra, M.D., MSc.

Ms. Meguma Ikarashi

Dr. Duong Huy Luong, M.D., PhD.

3. Contributors

Dr. Nguyen Thi Huong Giang, M.D., MSc., Head of Quality Management Department, Bach Mai Hospital

Dr. Do Van Thanh, M.D., PhD., Head of International Cooperation Department, Bach Mai Hospital

4. Secretariat

NCGM – Bach Mai Hospital Medical Collaboration Center (MCC), Hanoi, Vietnam

Ms. Pham Thi Phuong Thuy, MPH.

Dr. Nguyen Thi Le Hang, M.D., PhD.

Ms. Le Thi Thu Phong

5. Coordinator

National Center for Global Health and Medicine (NCGM)

Dr. Shinsuke Murai, Course Director, Strengthening Health Staff's Capability of Quality Management and Patient Safety in Healthcare Program

Ms. Megumi Ikarashi, Bureau of International Health Cooperation

6. Funding

The present forum was funded of the Program for International Promotion of Japan's Healthcare Technology and Services, FY2015 and conducted by National Center for Global Health and Medicine (NCGM) and Ministry of Health, Labor and Welfare, Japan

List of participants

No.	Name	Affiliation	Role
1	Duong Huy Luong	Medical Services Administration, Ministry of Health (MOH)	Speaker
2	Le Viet Nho	Quang Nam Central General Hospital	Speaker
3	Nguyen Thi Huong Giang	Bach Mai Hospital	Speaker
4	Nguyen Thi Huong Lien	Ha Dong General Hospital	Speaker
5	Pham Viet Thai	Ninh Thuan Provincial General Hospital	Speaker
6	Phan Anh Phong	Ha Nam Provincial General Hospital	Speaker
7	Ton Thanh Tra	Cho Ray Hospital	Speaker
8	Tran Quang Dat	Quang Nam Central General Hospital	Speaker
9	Tran Quang Hien	An Giang Obstetrics – Pediatrics Hospital	Speaker
10	Tran Quynh Anh	Thai Binh Provincial General Hospital	Speaker
11	Vu Thuy Giang	Ninh Binh Provincial General Hospital	Speaker
12	Pham Thi Thuy Dung	Cho Ray Hospital	Observer
13	Dinh Thi Ngoc Yen	Cho Ray Hospital	Observer
14	Nguyen Thi Thanh Cam	Quang Nam Central General Hospital	Observer
15	Bui Thi Minh Hien	Quang Nam Central General Hospital	Observer
16	Pham Thi Phuong Hanh	Ninh Binh Provincial General Hospital	Observer
17	Nguyen Thi Tuoi	Ninh Binh Provincial General Hospital	Observer
18	Nguyen Truc Quynh	Ha Dong General Hospital	Observer
19	Pham Quoc Tuan	Duc Giang General Hospital	Observer
20	Ho Thi Thu Hang	Vinh Long Provincial General Hospital	Observer
21	Do Van Thanh	Bach Mai Hospital	Observer
22	Nguyen Thi Ngoc Lan	Bach Mai Hospital	Observer
23	Vu Hang Hanh	Bach Mai Hospital	Observer
24	Nguyen Thi Nghe	Bach Mai Hospital	Observer
25	Hoang Viet Anh	Bach Mai Hospital	Observer
26	Nguyen Ngoc Phuoc	Bach Mai Hospital	Observer
27	Nguyen Thi Anh	Bach Mai Hospital	Observer
28	Nguyen Minh Chau	Bach Mai Hospital	Observer
29	Dang Thi Hai Duyen	Ha Nam Provincial General Hospital	Observer
30	Tran Ngoc Hoa	Ha Nam Provincial General Hospital	Observer
31	Nguyen The Toan	Quy Hoa Central Leprosy-Dermatology Hospital	Observer
32	Nguyen Dinh Hung	Saint Paul Hospital	Observer
33	Uong Thanh Tung	Saint Paul Hospital	Observer

No.	Name	Affiliation	Role
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35	Ha Ba Chan	Bac Ninh Provincial General Hospital	Observer
36	Nguyen Minh Quan	Thu Duc District Hospital	Observer
37	Huynh My Thu	Thu Duc District Hospital	Observer
38	Lu Quoc Hung	Hanh Phuc Hospital	Observer
39	Pham Huu Thuong	Hanoi Lung Hospital	Observer
40	Luong Ngoc Khue	MOH	Observer
41	Cao Hung Thai	MOH	Observer
42	Nguyen Trong Khoa	MOH	Observer
43	Vuong Anh Duong	MOH	Observer
44	Bui Quoc Vuong	MOH	Observer
45	Hoang Thi Hoa Ly	MOH	Observer
46	Dao Minh Nguyet	Thai Nguyen Central General Hospital	Observer
47	Do Hong Phuong	UNICEF	Observer
48	Pham Van Man	Dien Bien	Observer (JICA)
49	Luong Van Long	Dien Bien	Observer (JICA)
50	Hoang Van Hieu	Lao Cai	Observer (JICA)
51	Nguyen Duc Diep	Lao Cai	Observer (JICA)
52	Cao Ngoc Thang	Yen Bai	Observer (JICA)
53	Bui Ngoc Quynh	Yen Bai	Observer (JICA)
54	Ly Thi Huong Giang	Son La	Observer (JICA)
55	Sa Ngoc Hung	Son La	Observer (JICA)
56	Truong Quy Duong	Hoa Binh	Observer (JICA)
57	Vu Van Tu	Hoa Binh	Observer (JICA)
58	Do Thi Duong	Lai Chau	Observer (JICA)
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