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

Based on Proceedings and Discussions in the 2nd Vietnam Forum on Quality Management and Patient Safety, Da Nang, Vietnam in September 27-29, 2016

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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)” summarized discussion in the Vietnam Forum on Hospital Quality Management and Patient Safety in English. 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
CDC	Centers for Disease Control and Prevention (USA)
CQI	Continuous quality improvement
DI	Diagnostic imaging
DOH	Department of Health
DTMP	Division of Technical Medicine and Pharmacy
EBM	Evidence-based medicine
ENT	Ear, Nose, Throat
FE	Functional examination
GPD	General planning department
IRS	Incident reporting system
MOH	Ministry of Health
MSA	Medical Services Administration
OPD	Outpatient department
OT	Operation theater
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
SSC	Surgical safety checklist
SSI	Surgical site infection
WHO	World Health Organization

Session 1 How to Implement 5S Effectively?

Summary of Discussion

1. Making Plans of 5S

1. Purposes of 5S implementation should be identified and articulated, like in Thai Binh Provincial General Hospital.
2. A preferred approach to 5S implementation is a pilot implementation before expanding it to a larger scale. This helps Quality Management Department (QMD) staff learn how to apply 5S by themselves and how to collaborate with another department to help them apply 5S. A successful pilot can inspire other departments and successful departments can help other departments apply 5S in the future. For example, the Infection Control Department in Thai Nguyen Central General Hospital is now a 5S learning venue for not only other departments in the hospital but also other hospitals. A successful pilot can also help QMD convince the hospital leaders, especially the director, to involve in and support more for 5S activities.
3. QMD itself is a good place to conduct a pilot implementation. Besides, since many QMD heads are also leaders of other departments, usually a clinical one, they choose to do a pilot implementation in their clinical departments as well. For example, the National Hospital of Obstetrics and Gynecology chose to do a pilot implementation in QMD and Treatment Services Department because the QMD head is also the head of the other department. Ha Dong General Hospital did a pilot in three laboratories because the QMD head is also a deputy head of one laboratory. Some other hospitals, such as Tu Du Hospital, chose to start with departments who were most willing to work with QMD to try applying 5S.
4. Detailed division of work and labor in an activity plan is very important for implementers to know who does what and where. For example, Thai Binh Provincial General Hospital developed an assignment chart to assign specific staff to be in charge of specific areas: Mr. A in charge of room 1, Ms. B in charge of room 2, Mr. C in charge of the lobby on the 1st floor, Ms. D in charge of the lobby on the 2nd floor…

2. Training

1. Hospitals usually conduct general trainings on 5S to introduce the concept and relevant theories. However, such basic trainings are not enough. Usually after this type of training, medical staff still do not know how to apply 5S.
2. More detailed, hands-on trainings are necessary. This type of training can be developed after pilot implementation when QMD staff has more practical knowledge in their hospital context. This type of practical training should show participants what specific things should be done in each step (each S). For example, in Thai Binh Provincial General Hospital, the detailed trainings include showing how to organize an injection trolley and a drug cabinet step by step.
3. Tu Du Hospital's QMD designed some sorting exercises and setting-in-order exercises based on the skills needed for S1 and S2 and ask their training participants to do these exercises in the trainings. This helps participants imagine how to apply S1 and S2 in reality.
4. Use of photographs and actual examples can make trainings more interesting to participants and attract their attention.
5. Since many people tend to resist change, introducing 5S as a new concept may make it difficult for hospital staff to adopt it. Tu Du Hospital's QMD often relate 5S activity to a familiar custom, which is cleaning the house before new year.

3. Application

1. Some common things or places to start 5S application are working desks, document cabinets, drug cabinets,

injection trolleys, departments' administrative rooms, and corridors.

2. 5S requires working on the details. For example, in National Hospital of Obstetrics and Gynecology, QMD checked all contents of the drawers and cabinets they were to apply 5S, then categorized these contents to be able to sort (S1) and set things in order (S2).

3. Applying S1 often requires storage to store broken equipment to be handled later, because handling such broken equipment usually must follow a procedure and it takes time.

4. Applying S2 may requires more organizing boxes or shelves. Some hospitals can manage to buy new ones (e.g., National Hospital of Obstetrics and Gynecology, Ninh Binh Provincial General Hospital) while others may craft some hand-made boxes from available materials while waiting for funding to buy better ones (Thai Binh Provincial General Hospital).

5. QM staff should work directly with department staff "at the field" to identify what should be done in each step. In Thai Binh Provincial General Hospital, QM staff guides staff in other departments to think about: (i) At your working position, what is necessary for your work and what is not? (ii) For what is necessary for your work, what is the quantity you need? (iii) Where should you put these necessary things? etc.

6. A suggestion from Hue Central Hospital is that QMD works with each department, one by one. In Tu Du Hospital, QMD works intensively with the first implementing departments and gradually reduces their supporting role for the next implementing departments.

4. Monitoring and Evaluation

1. Monitoring helps keeping staff practice 5S regularly. Some relevant departments can help monitoring 5S implementation. For example, the Nursing Department in Ha Dong Hospital often check whether injection trolleys are organized in clinical departments, so compliance to 5S for injection trolleys is high. Quang Nam Central General Hospital experienced decreasing compliance to 5S when they reduced monitoring.

2. Some hospitals, such as Thai Nguyen Central General Hospital, Thai Binh Provincial General Hospital, Ninh Binh Provincial General Hospital, use a checklist to score and evaluate 5S implementation. (The checklist was developed under NORRED project.[1])

3. Quang Nam Central General Hospital checks inventory in a featured pilot department (Pediatrics) before and after 5S implementation to see the effectiveness of 5S.

4. In Thai Nguyen Central General Hospital, QMD collaborates with some members of other departments (e.g., Nursing Department, Pharmacy Department) to go and check 5S implementation. Since some departments were not cooperative, QMD invited a member of the hospital directing board to join and be the leader of the patrol team.

5. Taking photos is helpful for providing evidence of 5S results and spread lessons learnt. In Quang Nam Central General Hospital, some clinical departments take photos by themselves for self-monitoring.

5. Participation and Engagement

1. In departments that implement 5S, participation of department heads is the key to success. In some hospitals, involvement of departments' deputy heads and head nurses was not enough.

2. In Thai Binh Provincial General Hospital, some department heads were attracted by 5S trainings and they actively started 5S implementation in their departments while others were not.

3. In many hospitals, other departments question the QMD's roles and tasks and do not want to follow QMD. For these cases, participation of the directing board, especially the director, in 5S activities can help. For example, in Thai Nguyen Central General Hospital, QMD was successful in convincing their hospital director to chair the 5S Steering Committee as well as in inviting a member of the directing board to lead the patrol team.

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1. Northern East and Red River Delta Regions Health System Support Project

4. To win the director's support, QMD should show some evidence, according to experience of Tu Du Hospital and National Hospital of Obstetrics and Gynecology. In National Hospital of Obstetrics and Gynecology, after QMD reported their initial results of 5S implementation in QMD and Treatment Services Department, the hospital director asked them to apply 5S to his office.

6. Other Activities

1. Quang Nam Central General Hospital asked all departments to submit their 5S improvement initiatives and departments generated many good ideas.
2. In Thai Binh Provincial General Hospital, QMD was successful in convincing the hospital director and the Performance Evaluation Board to account 5S implementation into their evaluation system. For example, departments who score 1-2 in 5S implementation will be rated B, those who score 3 and above will be rated A.[2]

7. Practical Outcomes of 5S Implementation

1. In Pediatrics Department in Quang Nam Central General Hospital, the inventory reduces remarkably after 5S implementation.
2. In Thai Binh Provincial General Hospital, practices of 5S helped hospital staff learn to think about how to create a convenient and rational working environment. For example, in a 5S exercise, staff were divided into different teams and each team had to re-arrange an injection trolley. They came up with different ways to organize the trolley, different positions to put certain things. Then each team had to explain their organization and they discussed which way was the best.
3. In Bac Giang Provincial General Hospital, applying 5S made the hospital cleaner and helped attract more patients and increase hospital's income.

2. This ABC rating system affects the bonus each department receives monthly.

Session 1-1

5S Implementation in Clinical & Para-clinical Departments: Results & Lessons Learnt

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1. Vice Director, Quang Nam Central General Hospital
2. Quality Management Department, Quang Nam Central General Hospital

1. Reason for choosing the topic

5S is a foundational quality management (QM) program for continuous improvement, which helps control visualization, make tools and materials visible, easy to find, easy to get, and prevent troubles, damage and inadequacy when needed.

2. 5S itinerary at Quang Nam Central General Hospital (2 PDCA cycles)

The program was initiated by Nursing Department in June 2015. So far, the program has passed 2 evaluation cycles.

Cycle 1: Warm up (From June to December 2015)

- Nursing Department was the focal point to plan and organize 5S implementation in the nursing system. At the beginning, some departments participated actively, which generated some encouraging results. However, the expansion afterwards was slow. Some departments implemented perfunctorily, so their condition came back to square one after 1-2 weeks. In December 2015, through quick monitoring and evaluation, we recognized that the staff felt that 5S implementation was like a burden because it was time consuming and creating extra work. The people in charge of 5S implementation of the hospital and departments felt tired and discouraged.

- Finding and analyzing causes, we noticed three groups of problems but human factors and management policies are decisive. (Figure 1)

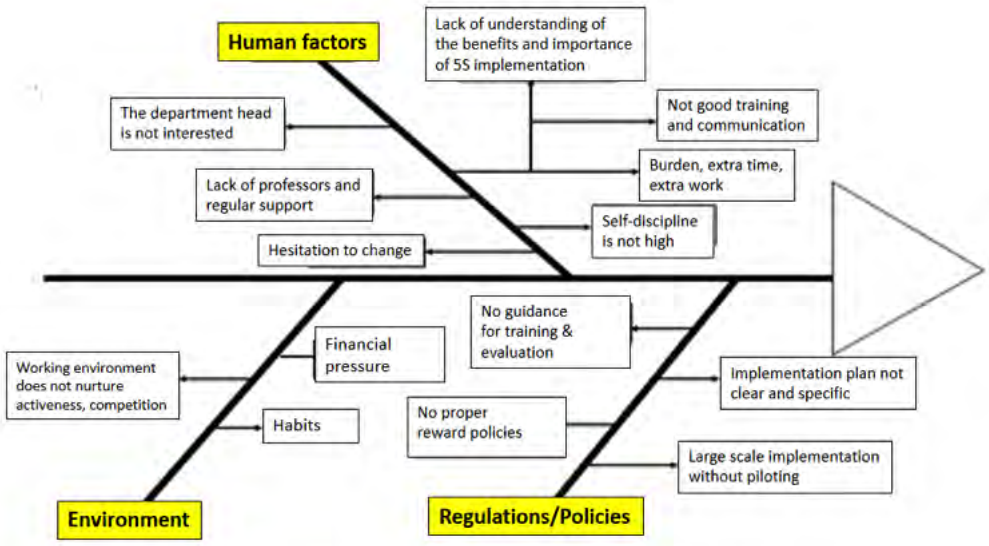


Figure 1: Causes of ineffective 5S implementation

Cycle 2: Objectives adjustment, development of intervention solutions (From January to October 2016): with 5 main solutions

- The scope of 5S implementation was narrowed to clinical and para-clinical departments

- A 5S supporting group was established to support Nursing Department and Quality Management Department (QMD)

- Core staff, especially department/unit leaders, were lobbied and their support was used

- A 5S evaluation scale was developed consensually; Monthly monitoring and support for implementation; Evaluation scores were announced, with images of what/ where needs improvement; Timely support, rewards and praises were given to well-implementing departments and those with improvement.

- Integrate "improvement initiatives" in daily 5S tasks.

Cycle 3: Expansion and enhancement of the program effectiveness

Currently, Nursing Department and QMD are evaluating comprehensively the effectiveness and challenges of this program to plan for next steps in order to maintain 5S effectiveness and expand to the whole hospital: involving functional departments, combining with other quality improvement (QI) programs such as LEAN management, etc.

3. Results

3.1. Direct effectiveness

- From observations and photos: the faces of many departments have changed remarkably: from reception, operation room, to consumables and equipment storage; from working desks, document cabinets, forms, drugs cabinets, to tools cabinets. Especially, injection and emergency trolleys are always arranged in a tidy, clean and convenient manner with logical labelling and marking, and clear identification, which facilitates work and avoids mistakes.

- Evaluation results using the 5S evaluation scale: there was remarkable improvement, with 24/27 (88.9%) departments achieving more than 80 points. Especially, many departments maintained these scores or showed more progress as results of other routine or unannounced evaluations.

- Results of inventory checking in Pediatrics Department:

- The quantity of inventory items reduced remarkably:
  - » Drugs: 5,142,198 VND reduced to 530,176 VND; Benefit: 4,612,022 VND
  - » Consumables: 1,406,799 VND reduced to 398,931 VND; Benefit: 1,007,868 VND
- There were no old, expired, or damaged items.

3.2. Results from a survey on 5S influence on staff perceptions

- With the question "Did 5S implementation increase work burden?": 72.3% of the responders said that 5S is part of their daily work; 18.1% acknowledged 5S effectiveness but felt tired with 5S maintenance; No responders said that 5S implementation is time consuming, burdening and tiring; 9.6% had other opinions (5S implementation creates self-discipline; it is difficult to maintain 5S).

- With the question "Has your department changed after 5S implementation?": 89.1% of the responders said that their departments had changed considerably, being tidier, cleaner, faster work thanks to less time for finding things and less repetitions of work due to mistakes; 7.2% said that their department had changed slightly; 2.4% had other opinions (the department had changed but sometimes things were not organized tidily due to staff's overwork).

3.3. Quantity and quality of improvement initiatives increased remarkably

- The number of improvement initiatives increased remarkably in 2015. At present, there are 46 improvement initiatives, 22 of which are related to 5S application (47.8%).

- The quality of initiatives has also been gradually improved.

4. Lessons learnt

- For 5S implementation:

- There must be a specific action plan (with clear division of work).
- Commitment of leaders: the success of 5S depends on departments leaders' supports and determination. The results of 5S implementation will be better in departments whose leaders are supportive and determined and regularly remind and encourage their staff. This is the most important factor for successful 5S implementation.
- Select an appropriate place for pilot

implementation: 5S will be implemented smoothly and successfully in departments whose leaders are strongly committed and whose responsible staff is enthusiastic and knowledgeable. This is an advantage for the 5S Committee to have time and condition to support. The successful departments provide guidance and share experience or errors to be avoided. If the pilot implementation is not successful, the adjustment will be easier, less time consuming and less costly. This is the second important factor for wide application of 5S.

- Monitoring and support are essential activities to help departments with difficulties in implementation or to praise and encourage well-implementing departments. The 5S Committee monitors and evaluates regularly and unannounced, using the evaluation scale, taking pictures of well implementing places and those that need improvement, showing such pictures to make people aware and improve...
- Trainings should be provided and communication activities should be conducted to make staff understand 5S benefits and how to implement 5S in their own departments (through training materials, communication slogans, sharing among departments…)
- For 5S implementers: be patient, do not rush.

5. Current challenges

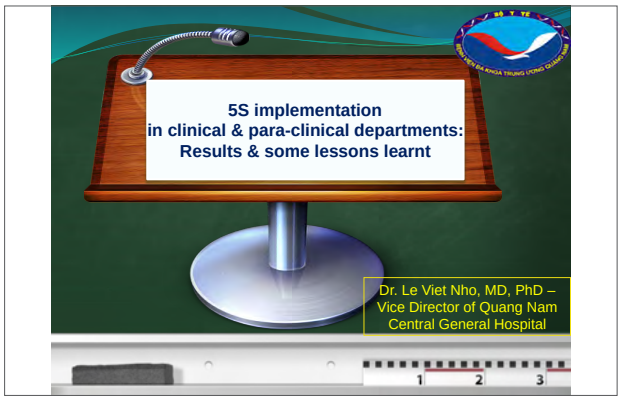
- 5S has not changed staff's old perceptions and habits, therefore some staff consider it as a trend, not as part of their daily work. Since they are not self-disciplined, monitoring takes time and effort.

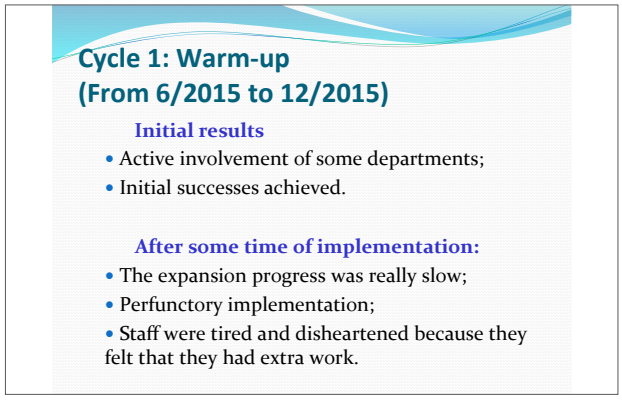
- Many doctors and departments leaders are not yet interested and do not understand the importance and benefits of 5S, thinking that it is the work of nurses or their lower staff.

- Many divisions think that 5S is necessary only for clinical and para-clinical departments, not for functional ones and it is difficult to implement 5S here.

6. Conclusions and recommendations

5S is not a costly QM program yet brings visible and clear results, sowing the first seeds of quality culture in hospital staff and serving as a foundation for other continuous QI programs. However, to ensure success, implementation must follow a PDCA cycle and implementers must always be patient. This program should be implemented widely in hospitals across the country, especially where QM has just started. After that, it can be expanded, upgraded and combined with other QM programs.





Cause analysis

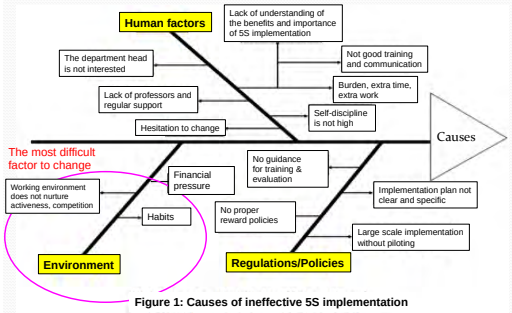


Figure 1: Causes of ineffective 5S implementation

Cycle 2: Objectives adjustment, development of intervention solutions

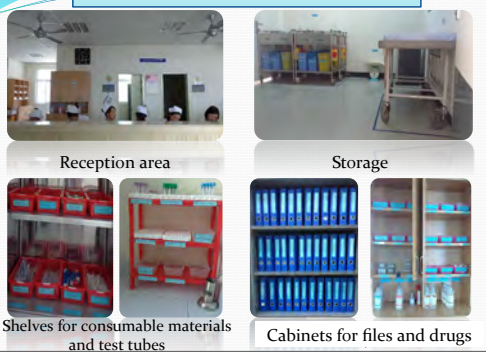
1. Focus : clinical and para-clinical departments
2. Establishment of 5S supportive group: nurses + QM staff
3. Mobilization of departments leaders
4. Monitoring + Rewards
   - Developing 5S evaluation scale
   - Conducting monthly monitoring and providing support
   - Releasing evaluation scores, showing images of where improvement is needed
   - Supporting and rewarding well-implementing departments and those with improvements
5. Integrating "improvement initiatives" in 5S tasks

5S IMPLEMENTATION IN PEDIATRIC DEPT.

Results achieved

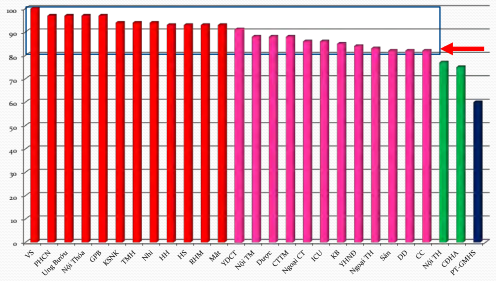
5S IMPLEMENTATION IN PEDIATRIC DEPT.

1.1. From direct observation



Operation Theater
Department of Anesthesia & Critical Care

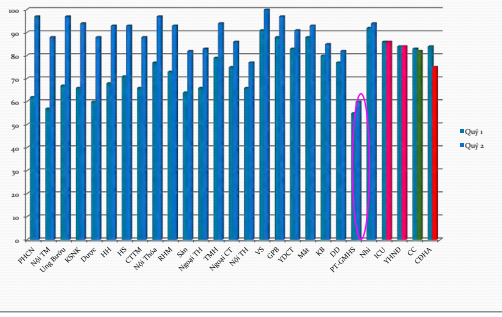
1.2. Evaluation results using 5S scale



3. Quality and quantity of improvement initiatives increased remarkably

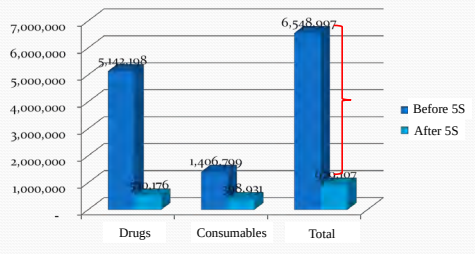
- Quantity increased remarkably compared with 2015:
  - 46 work improvement initiatives
  - 22 initiatives related to 5S (47.8%)
- Quality of initiatives also improved

Comparison of monitoring results Quarters 1, 2 of 2016



3. Lessons learnt

1.3. Results of inventory checking at the pilot department (Pediatrics):



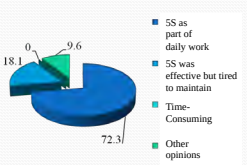
3.1. Making detailed plans with clear division of tasks

Gantt Chart

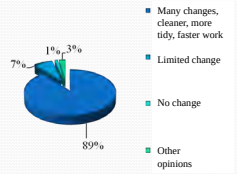
5S division of tasks

2. Survey results on impacts of 5S on staff perceptions

1. Did 5S implementation create more work burden?



2. Has the department changed after 5S implementation?



3.2. Leaders' commitment and support 5S Committee's enthusiasm and patience Everybody's participation

The most important factor

5S Committee: members → enthusiastic and have prestige in:

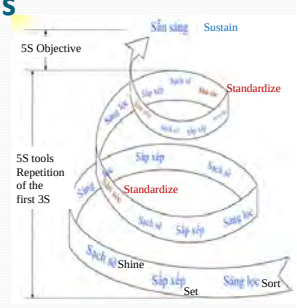
- Hospital
- Department

3.3. Pilot first, expansion later

The second most important factor

5. Conclusions

- 5S: improves quality continuously, not costly, but is effective and brings visible results.
- 5S should be applied in hospitals
- 5S implementation → following quality improvement procedure (PDCA) & implementers must keep patience



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3.4. Training - Communication

Training

Experience sharing

THANK YOU VERY MUCH

3.5. Monitoring, evaluation, support

- Developing 5S evaluation scale
- (5S Committee) Supporting and monitoring regularly
- Collecting scores, identifying (taking pictures of) areas where 5S haven't been implemented well
- Showing pictures to make everyone aware and change

4. Current challenges (Prior to Cycle 3)

- Some doctors, department leaders haven't paid enough attention and understood the importance and benefits of 5S.
- Old perceptions and habits haven't been changed, hesitation to change.
  - Considering 5S just a trend, not as part of work.
  - Other people's (lower staff') work.
- Self-discipline is not high.
- Working environment has not generated motivations for development.

Session 1-2

Evaluation of 5S Implementation in National Hospital of Obstetrics and Gynecology in 2016

Vu Van Du

Quality Management Department, National Hospital of Obstetrics and Gynecology

1. 5S implementation in National Hospital of Obstetrics and Gynecology

1.1. Introduction of National Hospital of Obstetrics and Gynecology

Organization and activities (Decision No. 806/QD-BYTdated March 12, 2013):

- Functional departments: 09
- Clinical departments: 14
- Para-clinical departments: 09
- Central departments: 07

1.2. Actual state

- Medical consumables, equipment, and nursing care devices were not arranged in a tidy and clean manner and not ready.
- There were many consumables in stock.
- Medical consumables and equipment were not standardized systematically.
- Individual awareness of department orderliness is not high enough.

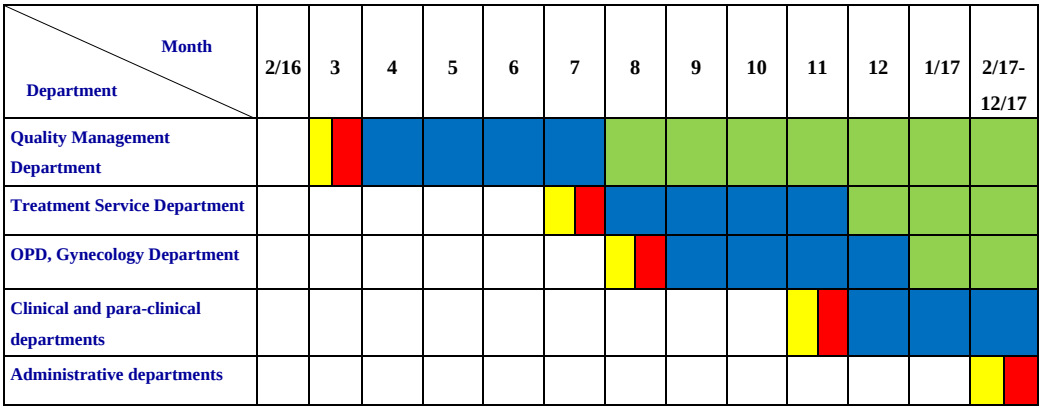
1.3. Consequences

- Not good looking
- Waste of materials.
- Risk of incorrect use of drugs, medical materials and devices.
- Waste of time.

1.4. Methodology

- Making plan for 5S implementation
- Selecting some departments for 5S implementation
- Implementing 5S
- Checking, monitoring
- Evaluating, reporting

1.5. Roadmap for implementation departments



Yellow color: training

Blue color: expansion

Green color: maintaining, monitoring

Red color: pilot implementation in small scale

2. Advantages - Difficulties

2.1. Advantages

- Support and facilitation from the Directing Board.

- Determination of leaders of departments.

- Active collaboration between QMD and other departments/units.

2.2. Difficulties

- Staff have limited perceptions of the meaning and benefits of 5S. Staff's self-discipline is not high enough.

- Teamwork skills and work progress are slower than planned. It takes much time to summarize proposals for procurement of materials.

- Checking and monitoring to maintain 5S are not regular and continuous.

3. Experience and lessons learnt

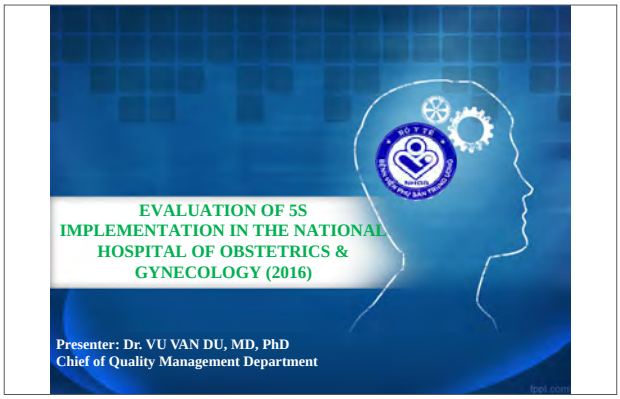
- Sharing knowledge to make staff recognize actual benefits of 5S in their daily work.

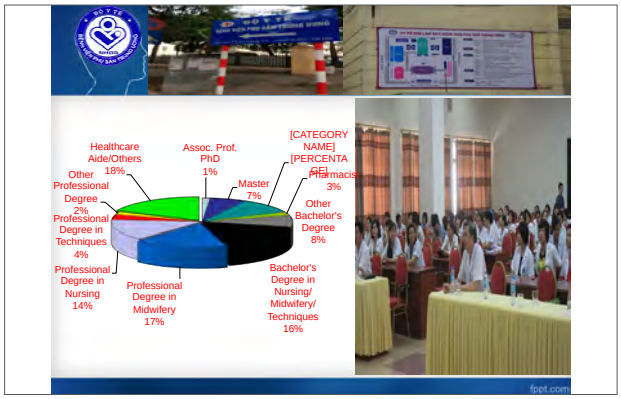
- Assigning specific tasks to each group with deadlines.

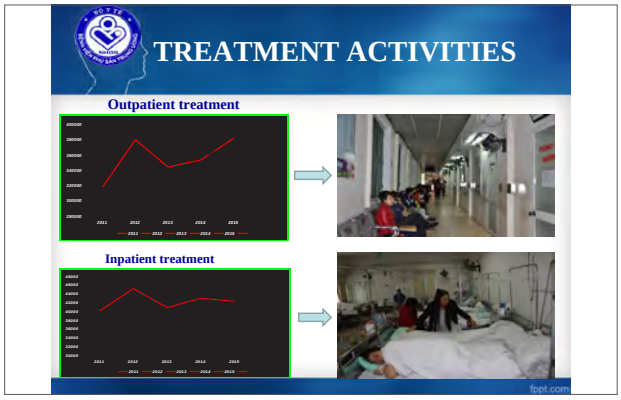
- Pilot implementation of 5S before expansion.

- Regular checking and monitoring to maintain 5S.

- Standardizing the arrangement of medical equipment and materials (documents, injection trolleys, drug cabinets...)







5S IMPLEMENTATION PROCESS

Actual state

- Medical materials, equipment and nursing care devices were not arranged in a tidy and clean manner and not ready to use.
- Considerable consumables were in stock.
- Medical equipment and materials were not standardized systematically.
- Individual awareness of department orderliness is not high enough.

IMAGES OF QMD AFTER 5S

Before **After**

5S IMPLEMENTATION PROCESS

Consequences

- Not good looking
- Waste of materials
- Risk of confusion related to: drugs, devices and medical materials
- Waste of time

⇨ Unsafe

⇨ Meeting to seek solutions ⇨ Consensus

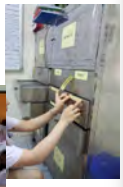
5S as a tool for quality improvement.

IMAGES OF QMD AFTER 5S

5S IMPLEMENTATION PROCESS

Methods

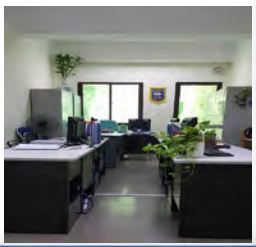
- **Planning for 5S implementation**
- **Selecting some departments for 5S implementation**
- **Implementing 5S**
- **Checking, monitoring**
- **Evaluating, reporting**



WORK MANAGEMENT ON COMPUTER

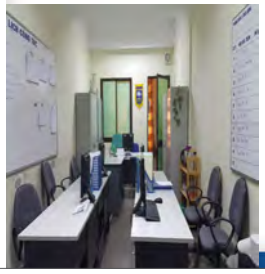
IMAGES OF QMD AFTER 5S

Before **After**



IMAGES OF QMD AFTER 5S

Before **After**



IMAGES BEFORE AND AFTER 5S

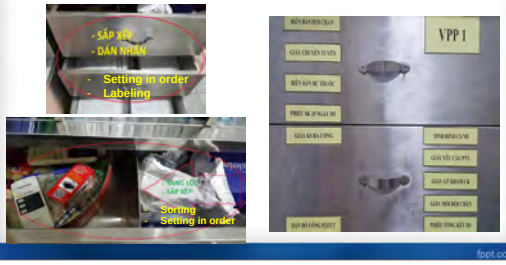
Before | After

IMAGES BEFORE AND AFTER 5S

Before | After

IMAGES BEFORE AND AFTER 5S

Before | After



5S FOR INJECTION TROLLEYS

Drawer of the injection trolley (Before) | Drawer of the injection trolley (After)

IMAGES BEFORE AND AFTER 5S

Before | After

5S FOR INJECTION TROLLEYS

Before | After

IMAGES BEFORE AND AFTER 5S

Before | After

5S FOR DRUG CABINETS

Before | After

5S FOR DRUG CABINETS

Before **After**

EXPERIENCE

- Sharing knowledge to make healthcare staff recognize actual benefits of 5S implementation in their work.
- Assigning specific tasks to each group with deadlines.
- Pilot implementation of 5S before expansion.
- Regular checking and monitoring to maintain 5S.
- Standardizing the arrangement of equipment and medical materials (medical records, injection trolleys, drug cabinets...)

ROADMAP FOR IMPLEMENTATION IN ALL DEPARTMENTS

Month	2/16	3	4	5	6	7	8	9	10	11	12	1/17	2/17-12/17
Quality Management Dept.													
Treatment Services Dept.													
OPD, Gynecology Dept.													
Clinical and paraclinical departments													
Administrative departments													

Blue: expansion

ADVANTAGES

- **Support of the Directing Board**
- **Determination of leaders of departments.**
- **Active collaboration between Quality Management Department and other departments/units.**

DIFFICULTIES

Staff have limited perception of the meanings and benefits of 5S.
Staff's self-discipline is not high enough.
Teamwork skills and work progress are slower than planned.
It takes much time to summarize proposals for → procurement of materials.
Checking and monitoring to maintain 5S are not regular and continuous.

Session 1-3

Evaluation Report on 5S Implementation in Thai Nguyen Central General Hospital

Dang Hoang Nga

Quality Management Department, Thai Nguyen Central General Hospital

1. Overview of 5S implementation in the hospital

From August 2015, QMD of Thai Nguyen Central General Hospital started implementing 5S to all departments/units in the hospital and obtained encouraging initial results.

Specific activities are as follows:

1. Guidance on 5S implementation was provided for leaders of departments: in August 20, 2015.
2. Departments develop their own plans, assign tasks, and implement 5S in their departments.
3. Departments disseminate information of 5S implementation in their departments.
4. Commitment on 5S implementation signed between staff and leaders of departments, and between leaders of departments with hospital director.
5. 5S slogans designed for departments. QMD collaborates with other departments to hang 5S slogans in departments to facilitate regular and continuous implementation.
6. QMD collaborate with some departments to monitor and evaluate 5S implementation in departments using a 5S+1 checklist
7. Results of 5S implementation in the hospital are reported

2. Results of 5S evaluation in August 2016

2.1. Survey tool: 5S+1 checklist

2.2. Results

- The number of evaluated departments: 40 departments (7 departments were not evaluated due to their moving to new places).

- Obtained results:

NO.	DEPARTMENT	AVERAGE SCORES						
		S1	S2	S3	S4	S5	S6	AVERAGE
1	Center for Training and Direction of Healthcare Activities	3.8	4	3	4	4.75	3	3.84
2	General Planning Department	3.8	3.6	3	2.83	3.75	3	3.34
3	Personnel Department	3.8	3.6	3	3.67	4.5	3	3.65
4	Finance and Accounting Department	3.8	3.8	2.8	3.83	4	3	3.61
5	Nursing Department	4	4	3.8	4	4.5	3	4
6	Social Affair Department	3.8	4	3	3.83	4.25	4	3.76
7	Administration Department	3.8	4	3	3	4.25	3	3.53
8	Medical Equipment and Materials Department	3.2	3.2	2	2,83	3.17	3.2	2.93
9	IT Department	3.4	3.2	3	3.17	3.23	3.6	3.26
10	Pharmacy department	3.8	3.8	3	3.83	4.47	4.4	3.9
11	Neurosurgery Department	3.8	3.8	3	3.67	3.93	4	3.7
12	Orthopedics Department	3.8	3.6	2.6	2.67	3.5	4	3.33
13	Gastroenterology Surgery Department	4.2	4.4	3.2	4	4.75	4.6	4.16
14	Urology Surgery Department	3.6	3.8	3	3.83	4	4	3.7
15	Cardiothoracic Surgery Department	3.6	3.8	3	3.83	4.25	4	3.76
16	ENT Department	3.8	3.8	3.4	4	4.6	4.6	4.03
17	Emergency and Critical Care Department	3.6	3.6	3	4	4.17	4	3.73

NO.	DEPARTMENT	AVERAGE SCORES						
		S1	S2	S3	S4	S5	S6	AVERAGE
18	Obstetrics Department	3.4	3.4	2.4	2.67	3	4	3.13
19	Oncology Center	3.4	3.2	2.8	3	4.5	2.6	3.2
20	Ophthalmology Department	3	3	2.8	3	3	2.6	2.9
21	Cardiovascular Internal Medicine Department	3.2	3.2	2	2.67	3.5	3.2	2.93
22	Gastroenterology-Urology Department	3.6	3.4	3	3	4	3	3.3
23	Endocrinology- Respiratory Department	3	3	2.6	2.83	3.5	3	2.96
24	Gerontology – Health Protection Department	3.6	3.2	3.2	3.17	3.5	3.8	3.4
25	Rheumatology Department	3	3.2	2.4	2.83	3.31	4	3.26
26	Tropical diseases Department	4	3.6	3	3.67	4.75	4.2	3.83
27	Mental Health Department	3.6	3.6	3	3.33	4	3.6	3.56
28	Neurology Department	3	3	3	3.33	4	3.6	3.3
29	Neonatal Pediatrics Department	3.8	4	3	4	4	4	3.96
30	Odonto-Stomatology Department	4	3.6	2.8	3.5	5	3.8	3.73
31	Traditional Medicine Department	3.8	3.8	3	3	4.5	4	3.63
32	Rehabilitation Department	3.6	4	3	3.67	4.28	3.6	3.73
33	Infection Control Department	4	4	4	4	4.6	4.2	4.13
34	Anesthesia Department	3.4	3.6	3.4	3.17	3.86	4	3.56
35	Outpatient Department	3.6	3.6	3	3.5	3.92	4	3.6
36	Examination Services Department	3.8	4	3	4	4.5	4.4	3.96
37	Dermatology Department	3.8	3.6	3	3.83	3.97	3.8	3.66
38	Nutrition Department	3.2	4	3	3.17	3.86	4.2	3.56
39	Emergency Department	3.6	4.6	3	3.33	4.22	4	3.86

- General evaluation:

Level / Classification	Very bad (0-<1)		Bad (1-<2)		Average (2-<3)		Good (3- <4)		Very good (4-5)	
S1	0	0%	0	0%	0	0%	35	87.5%	5	12.5%
S2	0	0%	0	0%	0	0%	29	72.5%	11	27.5%
S3	0	0%	0	0%	10	25%	29	72.5%	1	2.5%
S4	0	0%	0	0%	7	17.5%	25	62.5%	8	20%
S5	0	0%	0	0%	0	0	16	40%	24	60%
S6	0	0%	0	0%	2	5%	18	45%	20	50%
Overall	**0**	**0%**	**0**	**0%**	**4**	**10%**	**32**	**80%**	**4**	**10%**

2.3. Comments and recommendations for improvement

- Departments have actively implemented 5S

- After one year of implementation, certain improvement and results have been obtained. Staff practice 5S regularly at their working space.

- Administration Department is tidy.

- Logical arrangement of documents with labels to ease recognition and work, avoiding mistakes.

- 5S has been applied well to drug cabinets in departments. However, it should be maintained to avoid drug dispensing errors.

- Most of patient wards have implemented 5S well.

2.4. Some problems to overcome and cause analysis

- Division of tasks and monitoring in some department are still weak.

- 5S is not maintained regularly.

- Staff do not follow procedures and regulations properly: waste bins not over ¾ full; waste bins must have covers

- Patients and their families do not collaborate well with medical staff and do not follow hospital regulations properly.

2.5. Solutions for 5S implementation

- Establishing 5S Steering Committee in the hospital (Director is the chairman, Head of QMD a permanent member)

- Each department develops its own 5S plan at the beginning of the year and send it to QMD

- Using the tool 5S + 1 (6S) Checklist in the whole hospital.

- Departments have plans for regular internal monitoring and evaluation besides the hospital's monitoring and evaluation.

- Proper compliance to procedures and regulations on ensuring PS, pharmaceutical safety…

- Regularly reminding patients and their families to follow regulations of wards, departments and hospital.

- Infection Control Department re-train other departments how to arrange tool cabinets with aseptic principle.

- Clinical pharmacists group provide instructions and monitor departments' drug cabinets in accordance with drug use regulations and procedures.

- Administration Department add more beds, bed cabinets, and lockers for lacking departments.

- Nursing Department evaluate and re-train nurses in departments about regulations for injection trolley arrangement, safe injection procedures…

- QMD collaborate with other departments to monitor and support their 5S implementation.

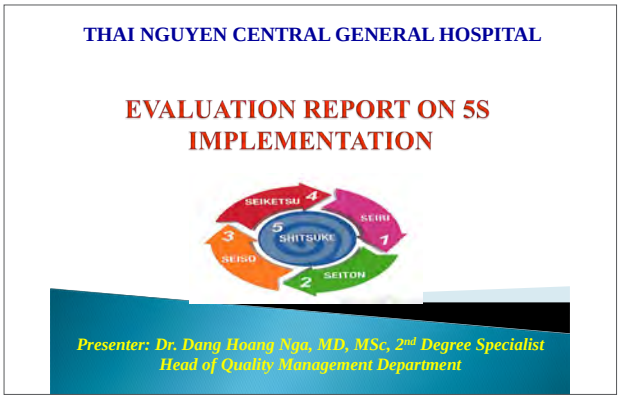
2.6. Conclusions

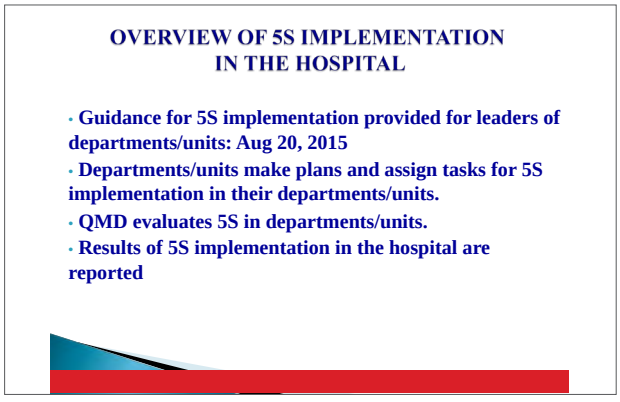
- Departments have basically started implementing 5S. The facilities look more tidy and bright despite limited infrastructure. However, besides current basic 5S practices, there are problems to overcome.

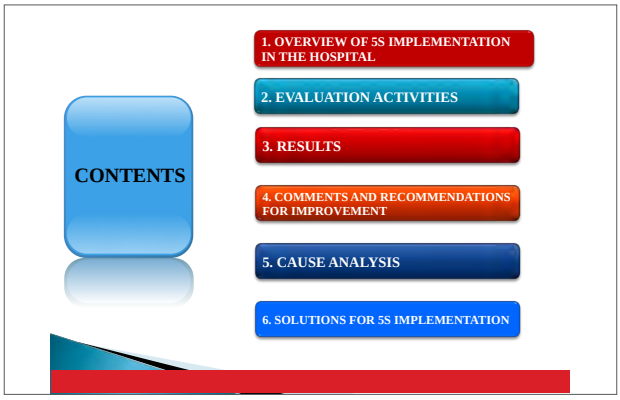
- 5S is one important content, a precondition for QI of each department as well as the whole hospital.

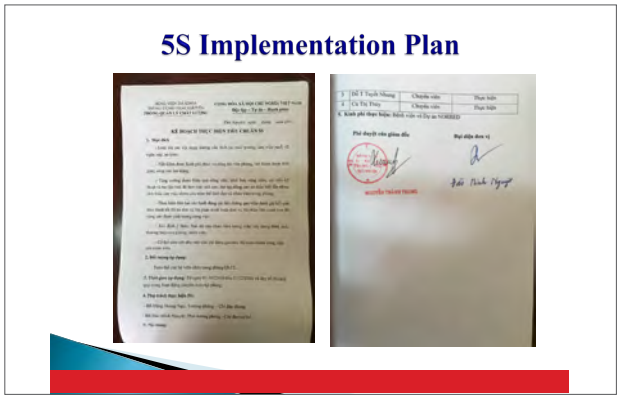
- 5S implementation (LEAN management) aims at reducing costs and risks and enhancing quality, patient satisfaction, quality and prestige of each department and the whole hospital.

- There should be further collaboration in 5S implementation among departments, between clinical departments and functional departments.



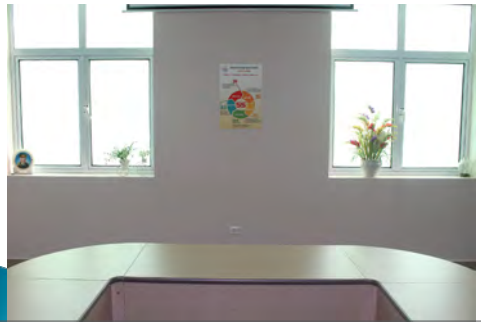






5S trainings in departments

Picture of 5S slogan



PHỤ LỤC 2.1

BỆNH VIỆN ĐA KHOA TRUNG ƯƠNG THÁI NGUYÊN

CỘNG HÒA XÃ HỘI CHỦ NGHĨA VIỆT NAM

Độc lập – Tự do – Hạnh phúc

CAM KẾT

Của Trưởng khoa/phòng/trung tâm với Giám đốc Bệnh viện về triển khai thực hiện các nội dung 5S

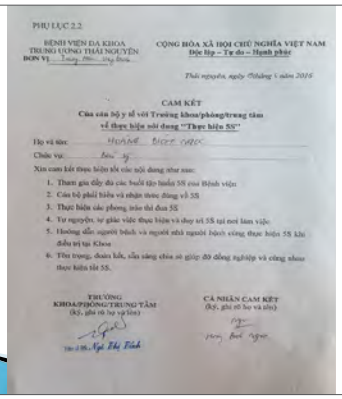
Trưởng Khoa/Phòng/Trung tâm:

GIÁM ĐỐC BỆNH VIỆN

TRƯỞNG KHOA/PHÒNG/TRUNG TÂM

5S Slogan

(Dept. of Tropical Diseases)



PHỤ LỤC 2.2

BỆNH VIỆN ĐA KHOA TRUNG ƯƠNG THÁI NGUYÊN

CỘNG HÒA XÃ HỘI CHỦ NGHĨA VIỆT NAM

Độc lập – Tự do – Hạnh phúc

CAM KẾT

Của cán bộ y tế với Trưởng khoa/phòng/trung tâm về thực hiện nội dung "Thực hiện 5S"

TRƯỞNG KHOA/PHÒNG/TRUNG TÂM

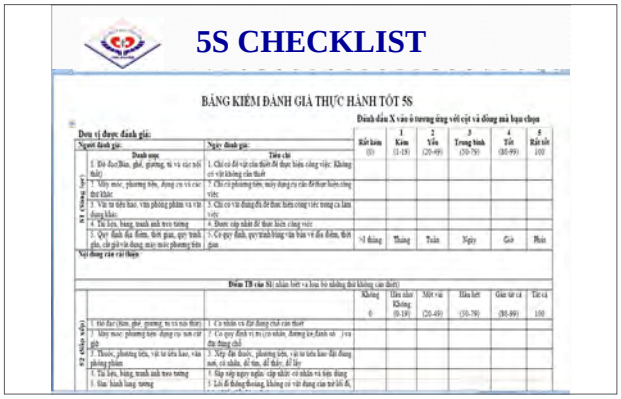
CÁ NHÂN CAM KẾT

5S Slogan

(Pathology Department)

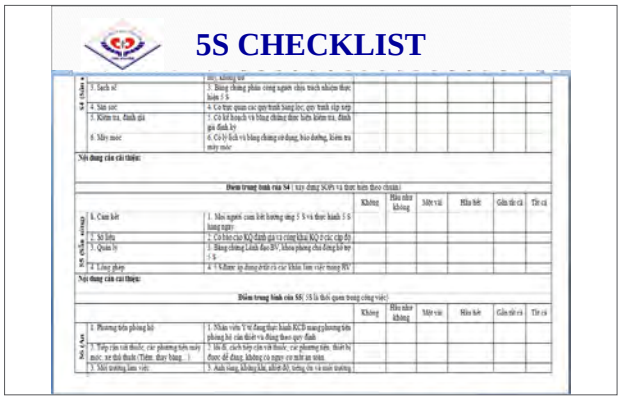
EVALUATION ACTIVITIES

- *Evaluators: Staff of QMD, Nursing Dept., Infection Control Dept., Pharmacy Dept., Administration Dept., and Social Affairs Dept.*
- *Implementation period: Aug 2015 to Aug 2016*
- *Evaluation time: Aug 2016*
- *Number of evaluated departments.: 40 (7 departments were not evaluated as they had recently moved to new places and not totally re-settled yet)*
- *Tool: A checklist was developed under the guidance of NORRED Project Management Committee with 30 criteria and 6 score levels (from 0 to 5)*



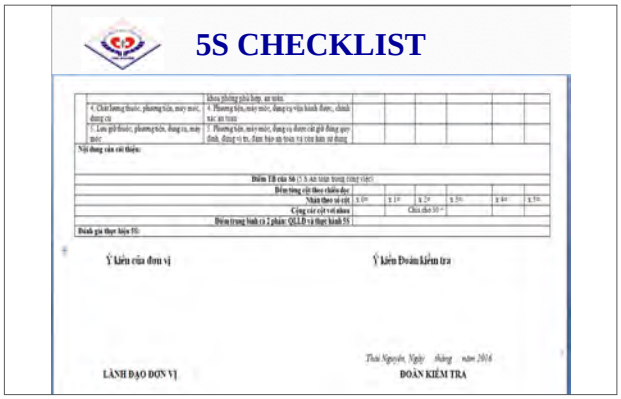
IMPLEMENTATION RESULTS

NO.	DEPARTMENT	AVERAGE SCORES						
		S1	S2	S3	S4	S5	S6	Average
11	Neurosurgery Department	3.8	3.8	3	3.67	3.93	4	3.7
12	Orthopedics Department	3.8	3.6	2.6	2.67	3.5	4	3.33
13	Gastroenterology Surgery Department	4.2	4.4	3.2	4	4.75	4.6	4.16
14	Urology Surgery Department	3.6	3.8	3	3.83	4	4	3.7
15	Cardiothoracic Surgery Department	3.6	3.8	3	3.83	4.25	4	3.76
16	ENT Department	3.8	3.8	3.4	4	4.6	4.6	4.03
17	Emergency and Critical Care Department	3.6	3.6	3	4	4.17	4	3.73
18	Obstetrics Department	3.4	3.4	2.4	2.67	3	4	3.13
19	Oncology Center	3.4	3.2	2.8	3	4.5	2.6	3.2
20	Ophthalmology Department	3	3	2.8	3	3	2.6	2.9



IMPLEMENTATION RESULTS

NO.	DEPARTMENT	AVERAGE SCORES						
		S1	S2	S3	S4	S5	S6	Average
21	Cardiovascular Internal Medicine Department	3.2	3.2	2	2.67	3.5	3.2	2.93
22	Gastroenterology-Urology Department	3.6	3.4	3	3	4	3	3.3
23	Endocrinology-Respiratory Department	3	3	2.6	2.83	3.5	3	2.96
24	Gerontology – Health Protection Department	3.6	3.2	3.2	3.17	3.5	3.8	3.4
25	Rheumatology Department	3	3.2	2.4	2.83	3.31	4	3.26
26	Tropical Diseases Department	4	3.6	3	3.67	4.75	4.2	3.83
27	Mental Health Department	3.6	3.6	3	3.33	4	3.6	3.56
28	Neurology Department	3	3	3	3.33	4	3.6	3.3
29	Neonatal Pediatrics Department	3.8	4	3	4	4	4	3.96
30	Pediatrics Department	4	4	3	4.17	5	4.2	4.03



IMPLEMENTATION RESULTS

NO.	DEPARTMENT	AVERAGE SCORES						
		S1	S2	S3	S4	S5	S6	Average
31	Odonto-Stomatology Department	4	3.6	2.8	3.5	5	3.8	3.73
32	Traditional Medicine Department	3.8	3.8	3	3	4.5	4	3.63
33	Rehabilitation Department	3.6	4	3	3.67	4.28	3.6	3.73
34	Infection Control Department	4	4	4	4	4.6	4.2	4.13
35	Anesthesia Department	3.4	3.6	3.4	3.17	3.86	4	3.56
36	Outpatient Department	3.6	3.6	3	3.5	3.92	4	3.6
37	Examination Services Department	3.8	4	3	4	4.5	4.4	3.96
38	Dermatology Department	3.8	3.6	3	3.83	3.97	3.8	3.66
39	Nutrition Department	3.2	4	3	3.17	3.86	4.2	3.56
40	Emergency Department	3.6	4.6	3	3.33	4.22	4	3.86

IMPLEMENTATION RESULTS

NO.	DEPARTMENT	AVERAGE SCORES						
		S1	S2	S3	S4	S5	S6	Average
1	Center for Training and Direction of Healthcare Activities	3.8	4	3	4	4.75	3	3.84
2	General Planning Department	3.8	3.6	3	2.83	3.75	3	3.34
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4	Finance and Accounting Department	3.8	3.8	2.8	3.83	4	3	3.61
5	Nursing Department	4	4	3.8	4	4.5	3	4
6	Social Affairs Department	3.8	4	3	3.83	4.25	4	3.76
7	Administration Department	3.8	4	3	3	4.25	3	3.53
8	Medical Equipment and Materials Department	3.2	3.2	2	2,83	3.17	3.2	2.93
9	IT Department	3.4	3.2	3	3.17	3.23	3.6	3.26
10	Pharmacy Department	3.8	3.8	3	3.83	4.47	4.4	3.9

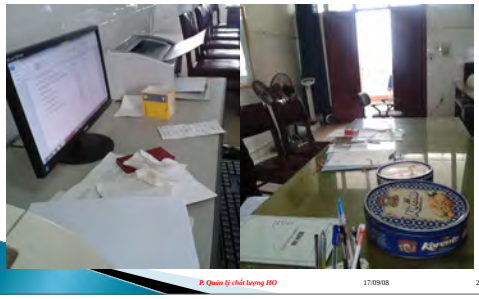
IMPLEMENTATION RESULTS

	Very bad (0-<1)		Bad (1-<2)		Average (2-<3)		Good (3- <4)		Very good (4-5)	
S1	0	0%	0	0%	0	0%	35	87.5%	5	12.5%
S2	0	0%	0	0%	0	0%	29	72.5%	11	27.5%
S3	0	0%	0	0%	10	25%	29	72.5%	1	2.5%
S4	0	0%	0	0%	7	17.5%	25	62.5%	8	20%
S5	0	0%	0	0%	0	0	16	40%	24	60%
S6	0	0%	0	0%	2	5%	18	45%	20	50%
Overall	0	0%	0	0%	4	10%	32	80%	4	10%

Some pictures before and after 5S implementation

Traditional Medicine Department

Before 5S



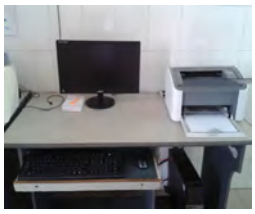
Functional Examination Department

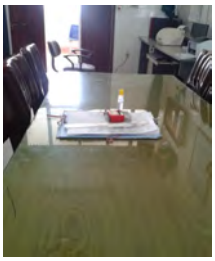
Before 5S

After 5S

Traditional Medicine Department

After 5S





Outpatient Department

Before

Pathology Department

Before 5S

After 5S

Outpatient Department

After

Injection room before implementing 5S

After implementing 5S

Document storage before implementing 5S

Patient wards before implementing 5S

- Bed cabinets were not tidy
- Patients did not lie orderly
- Patients' belongings were put everywhere

Document storage after implementing 5S

Patient wards after implementing 5S

Medical records

ICU

Patient wards after implementing 5S

Storage

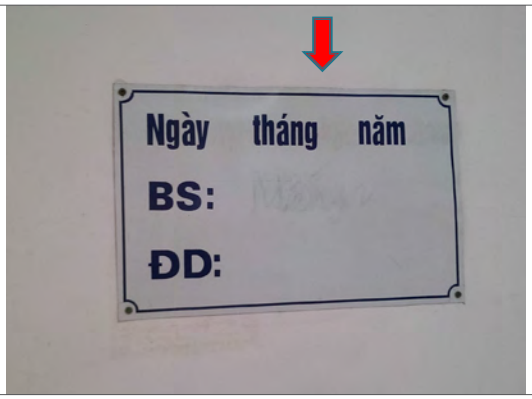
ICU

COMMENTS AND RECOMMENDATIONS FOR IMPROVEMENT

- Departments have actively implemented 5S.
- After 1 year, certain results and improvements have been obtained. Staff practice 5S regularly at their working space.
- Administration Department is tidy.
- Logical arrangement of documents with labels to ease recognition and work, avoiding errors.
- 5S has been applied well to drug cabinets. However, it should be maintained to avoid drug dispensing errors.
- Most of patient wards have implemented 5S well.

Some problems to overcome

P. Quản lý chất lượng BV 17/09/08 38

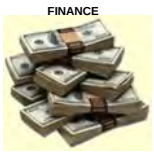


CAUSE ANALYSIS

- Division of tasks and monitoring in some departments are still weak.
- 5S is not maintained regularly.
- Staff do not follow procedures and regulations properly: waste bins not over ¾ full; waste bins must have covers…
- Patients and their families don't collaborate well with healthcare workers and don't follow hospital regulations.

P. Quản lý chất lượng HO

1. Leaders' commitment



SOLUTIONS FOR 5S IMPLEMENTATION

- Establishing 5S Steering Committee in the hospital (Director is the chairman, Head of QMD a permanent member)
- Each department develops its own 5S plan at the beginning of the year and sends it to QMD
- Using the tool 5S+1 (6S) checklist in the whole hospital
- Departments have plans for regular internal monitoring and evaluation besides the hospital's monitoring and evaluation
- Compliance to procedures and regulations on ensuring patient safety, pharmaceutical safety…
- Regularly reminding patients and their families about following the hospital's and departments' regulations

P. Quản lý chất lượng HO

2. Everybody's participation

SOLUTIONS FOR 5S IMPLEMENTATION

- Infection Control Department re-train other departments how to arrange tool cabinets with aseptic principle.
- Clinical pharmacists group provide instructions and monitor departments' drug cabinets in compliance with drug use procedures and regulations.
- Administration Department add more beds, bed cabinets, and lockers for lacking departments.
- Nursing Department evaluate and re-train nurses in departments about regulations for injection trolley arrangement, safe injection procedures…
- QMD collaborate with other departments to monitor and support their 5S implementation.

P. Quản lý chất lượng HO

3. Continuous improvement

- Always seeking inconveniences to improve.
- Always seeking untidy working places to improve.
- Seeking unsafe working areas to improve.
- Seeking unsafe and unclean working places to improve.
- Seeking wastefulness to remove.

MAIN CONTENTS

III The keys to maintaining 5S

1. Leaders' commitment
2. Everybody's participation
3. Continuous improvement
4. 5S advertised as a product
5. Regular internal evaluations
6. Acknowledgement of contributions

4. 5S advertised as a product

- Communicating 5S to people around
- Organizing competitions for 5S initiatives in departments
- Adding 5S information in hospital's LAN, website…

5. Internal 5S evaluation

- **Evaluation aims at:**
- Assessing the validity and relevance of the system
- Seeking opportunities for improvement

→ ***EVALUATION IS NOT PUNISHMENT***

6. Acknowledgement of contributions

- Acknowledgement of individual and collective contributions is cultural and a momentum for

COMMITMENT – FAITHFULNESS - DEVELOPMENT

Session 1-4

Results of 5S Practice in Thai Binh Provincial General Hospital: Difficulties and Advantages

Tran Thi Quynh Anh
Quality Management Department, Thai Binh Provincial General Hospital

1. Purpose of choosing 5S practice

- To develop a rational, convenient, and clean working environment.

- To reduce waste time and spend more time for professional activities.

- To limit medical incidents related to irrational working environment.

2. Objective

By 30 September 2016, 100% of departments practice 5S

3. Action plan

- Preparation stage: March 2016
  - » Planning
  - » Establishing a 5S taskforce
  - » Developing procedures and training materials
  - » Developing an evaluation checklist
  - » Training
- Implementation stage:
  - » Stage 1: Pilot implementation from May 1 to June 30, 2016
  - » Stage 2: Expansion from August 1 to September 30, 2016
  - » Stage 3: Comprehensive implementation from Nov 1 to Dec 30, 2016

4. Results

4.1. Training results

- Results of trainings on 5S knowledge: courses organized for 100% hospital staff:
  - » Course 1: Mar 14, 2016
  - » Course 2: Mar 18, 2016
  - » Course 3: Mar 25, 2016
  - » Course 4: Apr 1, 2016
  - » Course 5: Apr 8, 2016
- 3 advanced 5S courses organized:
  - » Training contents include: step-by-step guidelines for 5S implementation, arrangement of injection trolleys and drug cabinets, and experiencing 5S results.
  - » Training time: July 27, 28, 29, 2016

4.2. 5S practice results

- 5S Steering Committee and task force were established.

- 5S task force develop template 5S plans, practice materials, diagrams for division of work, evaluation checklists, labels, regulations for arrangement of injection trolleys, drug cabinets, and working places, and instruct departments to implement.

- Departments signed 5S commitment papers with the hospital director.

- Departments' staff basically understood 5S knowledge; departments developed 5S plans, assigned tasks to staff, and started sorting, setting, and shining step.

- Departments' working environment has encouraging initial changes:

- Unnecessary things removed, only useful things

kept in the working areas.

- Working rooms, administrative rooms, emergency rooms, drug storage, laboratories, medical waste areas, injection trolleys, on-duty drug cabinets were rearranged; labels applied to storage positions; safety principles (3 easy: easy for walking, easy for use, easy for transportation), convenience principles (5 easy: easy to find, easy to take, easy to see, easy to check, easy to clean) , and aesthetic principles (tidy, clean and nice-looking) ensured
- Areas have basically become cleaner than before.

- Some initiatives for organizing working areas:

- Old cardboard boxes are divided, numbered and labeled to contain drugs and consumable materials.
- Pharmacy Department: old cardboard boxes are used to contain unboxed drugs, labels are made from old drug boxes; different levels are created for newly-made boxes containing unboxed drugs for easy recognition, convenient dispensing, and avoiding errors.
- Injection trolleys are arranged in the same way, with clear regulation on where to put what.
- On-duty drug cabinets are arranged in the same way, with clear regulation on where to put narcotics, psychotropics, and normal drugs. Different types of drugs are labeled with different colors. The drug lists are printed with corresponding colors for easy recognition and minimizing errors.

5. Advantages – Difficulties

5.1. Advantages

- Hospital leaders' interest and directions to departments on 5S implementation.

- QMD's enthusiasm and activeness in 5S practice.

- The hospital has a small budget for 5S trainings.

- 5S practice as one content of hospital campaigns has contributed greatly to the success of 5S practice in the hospital.

- The 5S task force is enthusiastic and active in instructing and monitoring departments.

5.2. Difficulties

- Departments are not really active and self-disciplined in implementing 5S. Leaders of departments have not fully understood the purpose, meanings, and benefits of 5S therefore have not invested adequately in 5S.

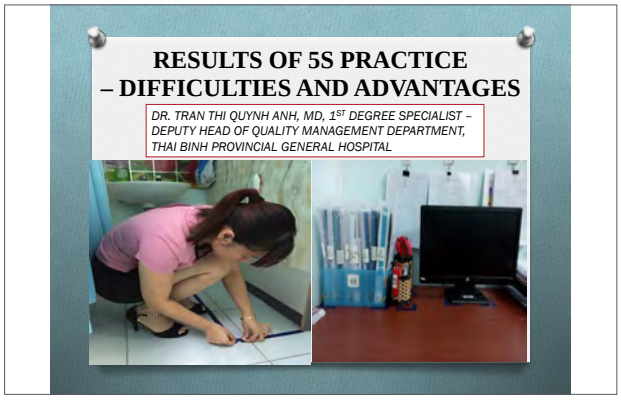
- Budget for 5S implementation is still limited, with no allowances for buying necessary things for renovating and replacing old and downgraded infrastructure and equipment.

- Shortage of manpower, overload of patients and lack of collaboration from patients and their families are some difficulties to 5S practice.

- Healthcare workers hesitate to change their old working habits.

- Some staff show non-collaborative attitude.

- Very few staff have good knowledge of 5S therefore it is difficult to instruct and monitor 5S implementation.



CONTENTS

1.Purpose and objectives of 5S practice in the hospital
2. Actual state of the hospital before implementing 5S
3. Implementation plan
4. Results
5. Difficulties and advantages

ACTUAL STATE BEFORE IMPLEMENTING 5S

PURPOSE

- To remove wastefulness
- To minimize redundant activities
- To develop a working environment with continuous improvement spirit
- To improve patient safety

Hospital Quality

ACTUAL STATE BEFORE IMPLEMENTING 5S

OBJECTIVES

By 30th September 2016, 100% departments in the hospital practice 5S

ACTUAL STATE BEFORE IMPLEMENTING 5S

ACTUAL STATE BEFORE IMPLEMENTING 5S

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ACTUAL STATE BEFORE IMPLEMENTING 5S

ACTUAL STATE BEFORE IMPLEMENTING 5S

ACTUAL STATE BEFORE IMPLEMENTING 5S

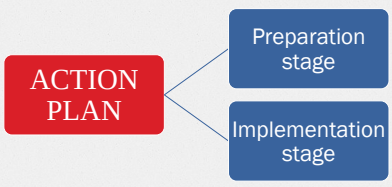
REASONS FOR 5S PRACTICE

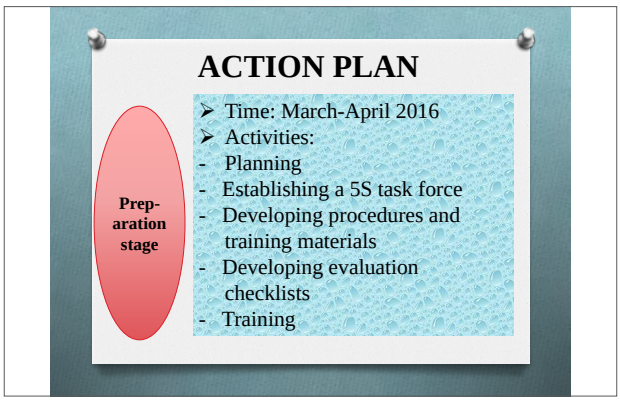
ACTUAL STATE BEFORE IMPLEMENTING 5S

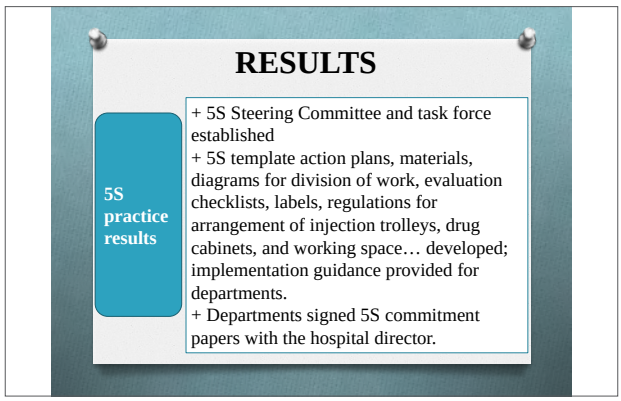
REASONS FOR 5S PRACTICE

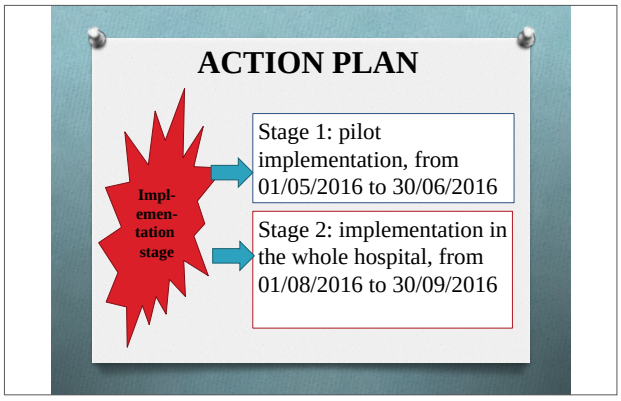
ACTUAL STATE BEFORE IMPLEMENTING 5S

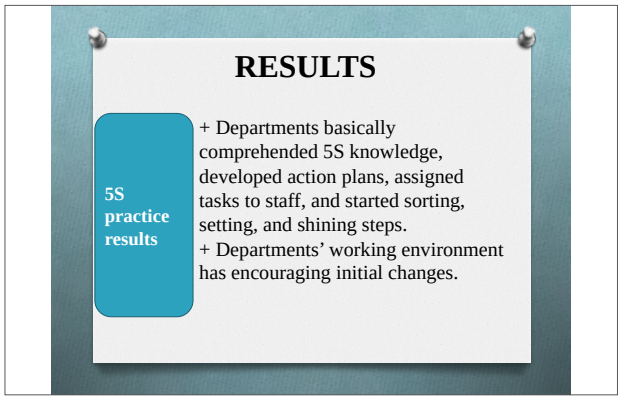
ACTION PLAN

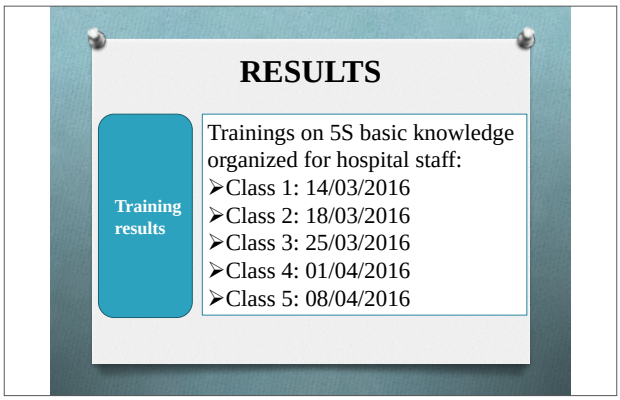


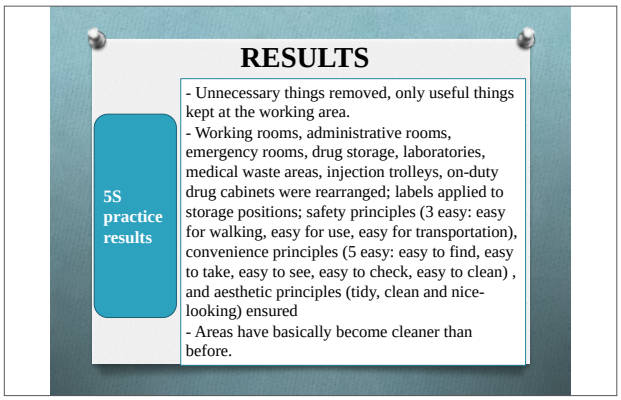

ACTION PLAN
Prep-aration stage
➢ Time: March-April 2016
➢ Activities:
- Planning
- Establishing a 5S task force
- Developing procedures and training materials
- Developing evaluation checklists
- Training

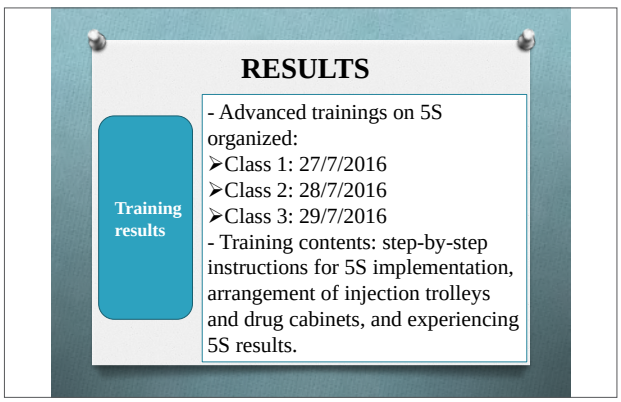

RESULTS
5S practice results
+ 5S Steering Committee and task force established
+ 5S template action plans, materials, diagrams for division of work, evaluation checklists, labels, regulations for arrangement of injection trolleys, drug cabinets, and working space… developed; implementation guidance provided for departments.
+ Departments signed 5S commitment papers with the hospital director.

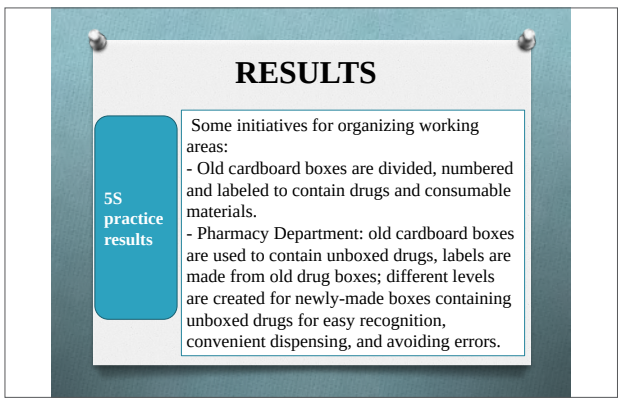

ACTION PLAN
Impl-emen-tation stage
Stage 1: pilot implementation, from 01/05/2016 to 30/06/2016
Stage 2: implementation in the whole hospital, from 01/08/2016 to 30/09/2016


RESULTS
5S practice results
+ Departments basically comprehended 5S knowledge, developed action plans, assigned tasks to staff, and started sorting, setting, and shining steps.
+ Departments' working environment has encouraging initial changes.


RESULTS
Training results
Trainings on 5S basic knowledge organized for hospital staff:
➢Class 1: 14/03/2016
➢Class 2: 18/03/2016
➢Class 3: 25/03/2016
➢Class 4: 01/04/2016
➢Class 5: 08/04/2016


RESULTS
5S practice results
- Unnecessary things removed, only useful things kept at the working area.
- Working rooms, administrative rooms, emergency rooms, drug storage, laboratories, medical waste areas, injection trolleys, on-duty drug cabinets were rearranged; labels applied to storage positions; safety principles (3 easy: easy for walking, easy for use, easy for transportation), convenience principles (5 easy: easy to find, easy to take, easy to see, easy to check, easy to clean) , and aesthetic principles (tidy, clean and nice-looking) ensured
- Areas have basically become cleaner than before.


RESULTS
Training results
- Advanced trainings on 5S organized:
➢Class 1: 27/7/2016
➢Class 2: 28/7/2016
➢Class 3: 29/7/2016
- Training contents: step-by-step instructions for 5S implementation, arrangement of injection trolleys and drug cabinets, and experiencing 5S results.


RESULTS
5S practice results
Some initiatives for organizing working areas:
- Old cardboard boxes are divided, numbered and labeled to contain drugs and consumable materials.
- Pharmacy Department: old cardboard boxes are used to contain unboxed drugs, labels are made from old drug boxes; different levels are created for newly-made boxes containing unboxed drugs for easy recognition, convenient dispensing, and avoiding errors.

RESULTS

5S practice results

- Injection trolleys are arranged in the same way, with clear regulation on where to put what.
- On-duty drug cabinets are arranged in the same way, with clear regulation on where to put narcotics, psychotropics, and normal drugs. Different types of drugs are labeled with different colors. The drug lists are printed with corresponding colors for easy recognition and minimizing errors.

5S PRACTICE

RESTRAINING FORCES IN 5S PRACTICE?

ADVANTAGES - DIFFICULTIES

Advan -tages

- Hospital leaders' interest and directions
- QMD's activeness
- The hospital has a small budget for 5S trainings
- Participation of the Hospital Competition and Reward Committee
- Departments' commitment
- The 5S task force's activeness and enthusiasm

RESTRAINING FORCES

1. Why do I have to remove and clean things when it's not my job?
2. How can we spend time for patients if we have to add 5S to our work?
3. We have been doing this for many years?
4. We are too busy for 5S?

ADVANTAGES - DIFFICULTIES

Diffi- culties

- Great expectations from hospital leaders
- Departments are not really active in implementing 5S
- Departments leaders have not recognized that "5S practice is for themselves", therefore have not invested adequately in 5S
- Old and degraded infrastructure
- Some departments' working places are subject to change
- Old and unsystematic equipment, lacking equipment

REMARKABLE INITIAL RESULTS

ADVANTAGES - DIFFICULTIES

Diffi- culties

- No funding for procurement of necessary things for 5S practice, infrastructure renovation, and upgrading equipment
- Shortage of manpower, overload of patients
- Patients and their families don't collaborate in 5S practice
- Hesitation to change old working habits
- Some staff show non-collaborative attitude
- Very few staff have good knowledge of 5S

INITIAL RESULTS OF 5S PRACTICE

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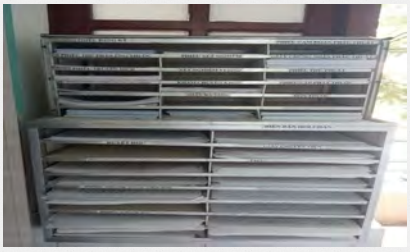
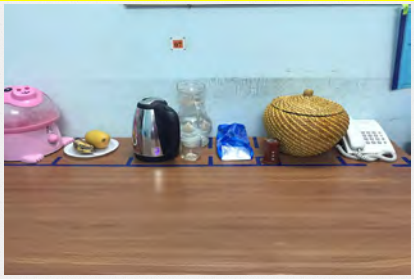


INITIAL RESULTS OF 5S PRACTICE



INITIAL RESULTS OF 5S PRACTICE

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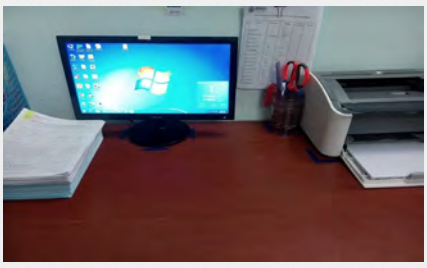

INITIAL RESULTS OF 5S PRACTICE

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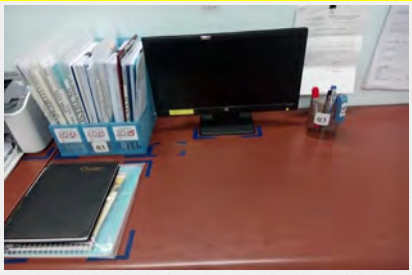

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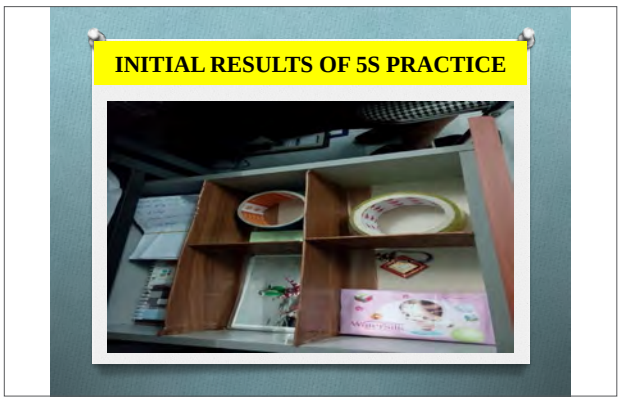
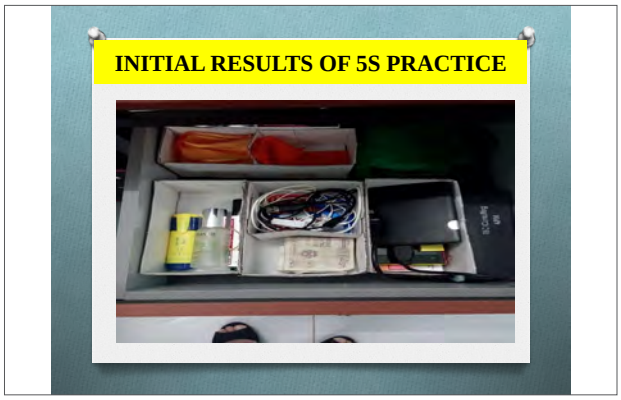

INITIAL RESULTS OF 5S PRACTICE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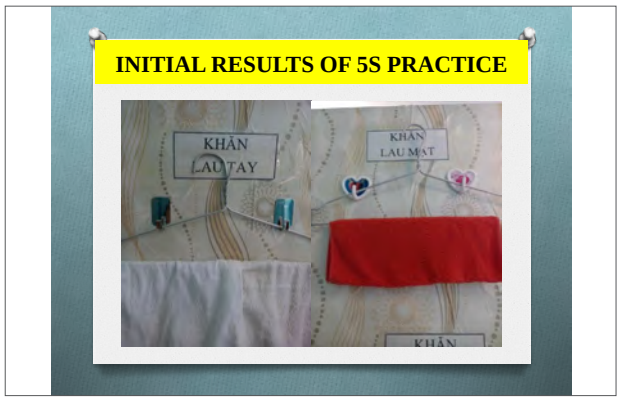
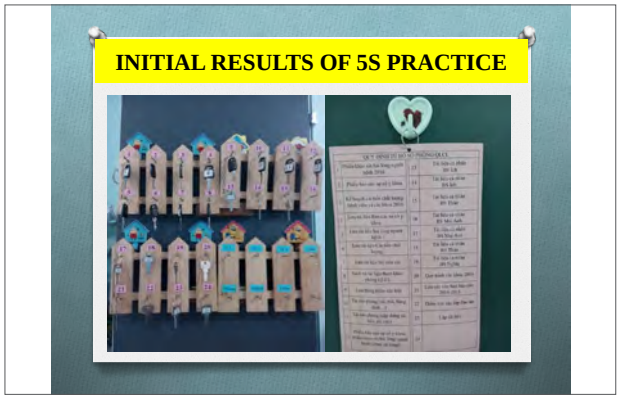

INITIAL RESULTS OF 5S PRACTICE
KHĂN LAU TAY
KHĂN LAU MẶT


INITIAL RESULTS OF 5S PRACTICE

Session 1-5

Challenges in 5S Implementation in Ha Dong General Hospital

Nguyen Thi Huong Lien

Quality Management Department, Ha Dong General Hospital

At present, departments are implementing "Hygienic Hospital". Three laboratories (Hematology – Blood Transfusion, Biochemistry, Microbiology) have been implementing 5S since December 2015. However, there are still some untidy arrangements. Therefore, 5S should be maintained to ensure effective work and comfortable working environment.

1. Advantages

1. From the hospital:

- Hospital leaders decided that 5S must be implemented in the hospital.

- 5S Steering Committee had been established and was reinforced in January 2016 with 20 members, including: Hospital Director as the chairman, heads of functional, clinical, and para-clinical departments.

- The Steering Committee has developed a 5S implementation plan, targeting three laboratories.

- 5S trainings were provided to leaders of departments.

2. From departments:

- The three laboratories have developed their 5S implementation plans.

2. Challenges: 2 groups

1. The Steering Committee and the guiding group (QMD, QM Network): are unexperienced and lack trainings.

- Departments are not monitored and evaluated regularly.

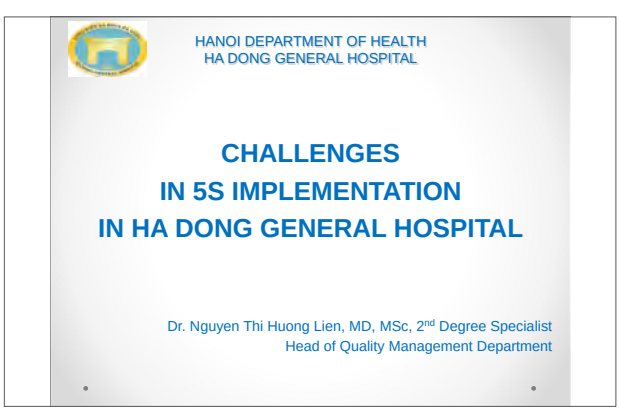
- Hospital budget does not prioritize 5S activities.

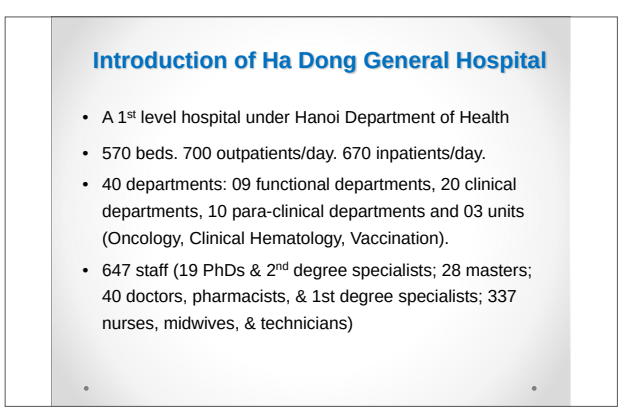
2. In laboratories:

- It takes time to change habits.

- 5S is being implemented under existing conditions: no budget allocated (equipment, stationary, etc.), lack and change of working rooms.

- Insufficient and unstable manpower.





Quality Management System

- 7/2014: QM Unit (3 members)
- 11/2015: QMD (5 members)

QM Network's meeting

Quality Management System

- QM Council: 43 members, including the Directing Board and chiefs of departments/units in the hospital.
- QM Network: 1-2 staff/department (total: 69 members).
- The Council and the Network meet every 3 months.

QI plan has been developed and implemented.

Opening ceremony of "Hygienic Hospital" campaign

QM Council's meeting

Implementing "Hygienic Hospital"

- Time: from May 2015
- Establishing 5S Steering Committee

Implementing 5S

Spend 5 minutes a day,
1 hour every Friday
for a green – clean – beautiful hospital

QM Network's meeting

Current state of Ha Dong General Hospital

- Departments are implementing "Hygienic Hospital".
- From December 2015: Pilot implementation of 5S in 3 laboratories: Hematology – Blood Transfusion, Biochemistry, Microbiology.
- 3 laboratories keep implementing 5S yet there are still some untidy arrangements.

=> Therefore, 5S should be maintained to ensure effective work and comfortable working environment.

5S evaluation checklist for clinical departments

Bảng kiểm đánh giá 5S

Khoa, phòng:

Đánh giá viên:			Ngày đánh giá:	Đánh giá	
Vị trí	TT	Mục	Nội dung đánh giá	Đ	KĐ
Buồng hành chính	1	Bàn/Ghế	Có sạch sẽ và được sắp xếp gọn gàng không?		
	2	Tủ	Có sạch sẽ và được dán nhãn chú thích rõ ràng không?		
	3	Hồ sơ bệnh án, phim XQ, sổ sách, giấy tờ, văn phòng phẩm	Có sạch sẽ, lưu trữ, xếp đặt ở vị trí hợp lý không?		
	4	Máy tính, máy in, điện thoại, dây điện, dây mạng, và các thiết bị khác	Có sạch sẽ, sắp xếp gọn gàng, phù hợp và được giữ gìn tốt không?		
	5	Bóng điện, điều hòa, quạt	Có sạch sẽ, an toàn và được bố trí hợp lý không? Còn sử dụng tốt hay không?		
	6	Tường, cửa sổ, sàn, trần	Có sạch sẽ và được giữ gìn tốt không?		
	7	Các bảng thông tin, giấy dán trên tường	Có sạch sẽ và bố trí hợp lý, cập nhật không?		
Buồng tiêm, buồng thủ thuật	8	Xe tiêm	Có sạch sẽ và được bố trí gọn gàng, hợp lý không?		
	9	Tủ thuốc	Có sạch sẽ và được dán nhãn phân loại không?		
	10	Tủ, giá để đồ, dụng cụ	Có sạch sẽ và được dán nhãn phân loại không?		
	11	Các thiết bị y tế	Có sạch sẽ, sắp xếp gọn gàng, sử dụng tốt không?		
	12	Bóng điện, điều hòa, quạt	Có sạch sẽ, an toàn và được bố trí hợp lý không? Còn sử dụng tốt hay không?		
	13	Tường, cửa sổ, sàn, trần	Có sạch sẽ và được giữ gìn tốt không?		
Kho lưu trữ	14	Xếp xếp các vật dụng	Các vật dụng trong kho có được xếp xếp hợp lý dễ tìm, dễ lấy không?		
	15	Các vật thừa, hỏng, không sử dụng	Có được lưu trữ tách biệt, xếp xếp hợp lý và dán nhãn đồ theo quy định không?		

Advantages

1. Hospital leaders: "5S implementation is really important and necessary, which contributes to improved quality of examination and treatment".
2. In January 2016, 5S Steering Committee was reinforced (with 20 members) including: Hospital Director as the chairman; chiefs of functional, clinical and para-clinical departments.
3. The Committee has made 5S implementation plan, starting with 3 laboratories and administrative rooms in all clinical departments.
4. 1/3 of hospital staff have been trained on 5S.

5S evaluation checklist for laboratories

Buồng/phòng XN

TT	Vị trí / Mục/ND đánh giá	B. phát máu		B. XN cơ bản 1		B. XN cơ bản 2		P. pha hóa chất		Ghi chú
		Đ	KĐ	Đ	KĐ	Đ	KĐ	Đ	KĐ	
1	**Tường, cửa sổ, sàn, trần**: Có sạch sẽ và được giữ gìn tốt không?									
2	**Bóng điện, điều hòa, quạt**: Có sạch sẽ, an toàn và được bố trí hợp lý không? Còn sử dụng tốt hay không?									
3	**Bàn/Ghế**: Có sạch sẽ và được sắp xếp gọn gàng không?									
4	**Tủ**: Có sạch sẽ và được dán nhãn chú thích rõ ràng không?									
5	**Ổ cảm điện**: cao hơn nền phòng 40cm, không gần với nước									
6	**Chỗ để quần áo và đồ dùng cá nhân**: có tiện lấy không?									
7	**TTB phòng cháy chữa cháy**: hoạt động tốt không? Sắp xếp hợp lý không?									
8	**Chất độc hại**: có biển báo không?									
9	Phân loại rác đúng qui định? (vị trí, màu sắc, phân loại…)									
10	TTB có sắp xếp gọn gàng, sạch sẽ không?									
11	TTB có đầy đủ thông tin (tên, số seri, ngày đưa vào sử dụng, lý lịch máy, hướng dẫn sử dụng…) có rõ ràng không?									
12	TTB có nhật ký sử dụng máy không?									

5S evaluation checklist for Biochemistry Department

Buồng phòng XN

TT	Vị trí / Mục/ND đánh giá	P. XN nước tiểu		P.XN máu		Ghi chú
		Đ	KĐ	Đ	KĐ	
1	**Tường, cửa sổ, sàn, trần**: Có sạch sẽ và được giữ gìn tốt không?					
2	**Bóng điện, điều hòa, quạt**: Có sạch sẽ, an toàn và được bố trí hợp lý không? Còn sử dụng tốt hay không?					
3	**Bàn/Ghế**: Có sạch sẽ và được sắp xếp gọn gàng không?					
4	**Tủ**: Có sạch sẽ và được dán nhãn chú thích rõ ràng không?					
5	**Ổ cảm điện**: cao hơn nền phòng 40cm, không gần với nước					
6	**Chỗ để quần áo và đồ dùng cá nhân**: có tiện lấy không?					
7	**TTB phòng cháy chữa cháy**: hoạt động tốt không? Sắp xếp hợp lý không?					
8	**Chất độc hại**: có biển báo không?					
9	Phân loại rác đúng qui định? (vị trí, màu sắc, phân loại…)					
10	TTB có sắp xếp gọn gàng, sạch sẽ không?					

Pharmacy Department

5S evaluation checklist for Microbiology Department

Buồng phòng XN

TT	Vị trí / Mục/ND đánh giá	P. XN vi khuẩn		P. nhận mẫu & trả KQ		P. nuôi cấy, phân lập VK		P.nuôi trường		P. sinh học phân tử		P. XN miễn dịch		P. sấy bếp dụng cụ	
		Đ	KĐ	Đ	KĐ	Đ	KĐ	Đ	KĐ	Đ	KĐ	Đ	KĐ	Đ	KĐ
1	**Tường, cửa sổ, sàn, trần**: Có sạch sẽ và được giữ gìn tốt không?														
2	**Bóng điện, điều hòa, quạt**: Có sạch sẽ, an toàn và được bố trí hợp lý không? Còn sử dụng tốt hay không?														
3	**Bàn/Ghế**: Có sạch sẽ và được sắp xếp gọn gàng không?														
4	**Tủ**: Có sạch sẽ và được dán nhãn chú thích rõ ràng không?														
5	**Ổ cảm điện**: cao hơn nền phòng 40cm, không gần với nước														
6	**Chỗ để quần áo và đồ dùng cá nhân**: có tiện lấy không?														
7	**TTB phòng cháy chữa cháy**: hoạt động tốt không? Sắp xếp hợp lý không?														
8	**Chất độc hại**: có biển báo không?														
9	Phân loại rác đúng qui định? (vị trí, màu sắc, phân loại…)														
10	TTB có sắp xếp gọn gàng, sạch sẽ không?														

Difficulties

1. The Steering Committee and guiding group (QMD and QM Network):

- Are unexperienced and lack trainings. Most of them have other roles.
- Departments are not monitored and evaluated regularly.
- Hospital budget does not prioritize 5S activities.

Some pictures of the hospital

Difficulties

2. In laboratories:

- Manpower: People have not recognized advantages of 5S implementation. Shortage of manpower leads to each person taking different positions.
- Facilities: Lack of rooms, narrow laboratories, change of rooms and position, no cabinets nor shelves for documents, etc.
- Environment: Untidy arrangements, many unnecessary things at the working space.

=> It takes time and money to change habits.

5S actual state of the hospital

Solutions

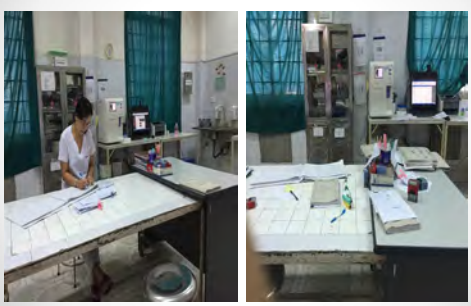
Making detailed 5S implementation plans for laboratories and some departments in the hospital:

- Establishing 5S monitoring groups in laboratories and Pharmacy Department.
- Training members who involves in monitoring activities.
- Monitoring as planned.
- Implementing 5S at administrative rooms in clinical departments.

Actual state in Hematology - Blood Transfusion Dept.

Some pictures of the hospital

Actual state in Hematology - Blood Transfusion Dept.



Hematology - Blood Transfusion Dept. implementing 5S

Biochemistry Dept. implementing 5S

Hematology - Blood Transfusion Dept. implementing 5S

Biochemistry Dept. implementing 5S

Microbiology Dept. implementing 5S

Biochemistry Dept. implementing 5S

Microbiology Dept. implementing 5S

Biochemistry Dept. implementing 5S

Biochemistry Dept. implementing 5S

Vaccination Unit of
Ha Dong General Hospital

Biochemistry Dept. implementing 5S

RECEIVING JAPANESE TEAM

WAITING AREA FOR PATIENT FAMILY

Japanese visitors at ICU

Vaccination Unit of
Ha Dong General Hospital

Workshop on Patient Safety and
Infection Control


THANK YOU !
BỆNH VIỆN ĐA KHOA HÀ ĐÔNG
HADONG GENERAL HOSPITAL

Session 2 How to Make Incident Reporting System Work?

Summary of Discussion

1. Purposes for Incident Reporting System

1. An incident reporting system (IRS) is expected to be a more systematic approach to collect information about incidents and therefore generate measures to increase patient safety in the hospital. Before establishing the IRS, a hospital may have been applying different single methods to ensure patient safety. For example, before IRS, Quy Hoa National Leprosy - Dermatology Hospital (hereafter referred to as Quy Hoa Hospital) relied on the following three activities to ensure patient safety in the hospital:
   a. Applying surgical safety checklist;
   b. Double-checking medications before giving them to patients; and
   c. Checking technical procedures
2. In Quy Hoa Hospital, IRS is expected to help (i) prevent near misses before occurrences of incidents that actually affect patients in the future or (ii) solve consequences of incidents that already affected patients.
3. Tu Du Hospital's motto for IRS is "One's incident is a lesson for another one".

2. Establishing IRS

In order to establish IRS, usually the following components are needed:

1. An official decision by the hospital director to approve the establishment of IRS in the hospital.
2. Working bodies and staff in-charge. In Vietnam, the Ministry of Health (MOH) recommends that each hospital establishes (i) a QM council, (ii) a QM department/unit, and (iii) a QM network. Besides this common structure, some hospitals, e.g., Tu Du Hospital and Cho Ray Hospital appoint one QMD staff to be specifically in charge of IRS management.
3. A reporting form, which hospital can use a paper-based form, electronic form or both of them. The form should contain headings to help the reporter know what information is needed, usually very basic information.
4. Different channels to receive incident reports, such as: direct delivery to QMD, an email exclusively used to receive reports, LAN, a phone line…
5. An incident handling form for QMD staff.
6. Procedures of how to report and handle an incident.
7. General training for hospital staff so that they know what they should report, to whom a reporter should submit a report, when, and how.
8. Training for QMD staff so that they know how they should receive and handle incident reports, and what they should do after receiving an incident report.

3. Barriers to Run IRS

1. Hospital staff do not want to share that they committed mistakes. Some are afraid of punishment.
2. Many hospital leaders are concerned about confidentiality of incident reports. They are afraid that if some information is revealed to a journalist, they may face public pressure for letting incidents happen in their hospitals. Therefore, hospital leaders may limit their support for IRS development.
3. The reporting system might not be convenient for reporters, therefore the system itself discourages hospital staff

to report. For example, in Tu Du Hospital, many clinical and para-clinical departments did not have printers so sometimes they did not have paper forms to fill in. Another barrier for handing paper reports was that QMD is on the 3rd floor with no elevator and not located in the same building with many departments.

4. How to motivate hospital staff to report?

1. At the beginning, QMD staff can directly look for incidents and ask other staff to report these incidents. It is like helping other staff to practice reporting incidents. For example, in Tu Du Hospital, when QMD staff walk around the hospital to check regular activities and detect an incident in a department, they inform a staff in that department about the incident and ask this staff to submit a report.
2. The hospital director can remind hospital staff to report incidents in hospital regular meetings, especially in weekly meetings with department leaders.
3. In Cho Ray Hospital, QMD staff attend head nurses' meetings to remind and encourage them to report incidents.
4. Praises from hospital leaders for departments that submit incident reports can encourage their staff to report incidents. In Tu Du Hospital, one department head was not happy to know that somebody in his department had submitted an incident report to QMD. However, before he could blame his staff, the hospital director gave him praise for his department's submission of incident reports in the next meeting. After that, this department head started encouraging his staff to report incidents; sometimes he reports by himself.
5. In return, QMD should motivate hospital leaders to involve in and support IRS activities. In Tu Du Hospital, QMD, on behalf of the QM network, gives honor awards to their hospital leaders to thank them for their companion and supports for IRS and other QM activities.
6. In An Giang Provincial General Hospital, submission of incident reports is counted in the hospital's performance assessment mechanism, which may affect the bonus a department can receive.
7. Hospitals can nurture a safety and learning culture by:

   a. Conducting a patient safety culture survey to identify intimidating factors of the hospital environment.

   b. Organizing trainings on soft skills for hospital staff to enhance mutual understanding, communication, and teamwork among them.
8. In Tu Du Hospital, trainings play an important role in motivating hospital staff to report incidents. At the beginning, the hospital's committed director required all hospital's key staff (i.e., department heads and deputy heads, head nurses…) to attend trainings. However, because the trainings were interesting and practical, these key staff were encouraged to motivate their staff to follow, with further support from QMD. Please see below for more details.

5. Training

(Mainly from Tu Du Hospital's experience)

1. Tu Du Hospital's QMD adopts some engaging and interactive training techniques from soft skills trainings previously organized in the hospital by outside trainers. QMD staff work with these trainers to integrate QM/PS contents into the trainings and gradually become trainers, being able to design and conduct trainings by themselves.
2. Sometimes, especially at the beginning, inviting outside trainers may make the trainings more convincing to hospital staff even though QMD staff can conduct trainings by themselves.
3. Gameshow and competition formats can excite participants and engage them in training. With IRS-related knowledge built in the games, participants can practice recognizing and categorizing incidents, which are some necessary skills for reporting incidents.
4. A common format used in Tu Du Hospital is that of "The Path to Olympia Peak" gameshow, in which competing teams earn scores by answering multiple-choice questions. Wrong answers are opportunities for discussion among participants and can help them memorize the knowledge better.
5. Since it may be difficult to involve every staff in trainings, trainings of trainers (TOT) might help. In Tu Du Hospital,

QMD organize trainings for key staff first, then assist some of them to organize trainings for their staff in their departments.

6. Analyzing incidents

1. For hospitals at early stages of development of IRS, analysis of incidents is not easy. In Quy Hoa Hospital, it took them a whole day to discuss three incidents with no clear final conclusions.
2. The depth of analysis depends on the severity and complexity of the incident. For more simple incidents, analysis can be conducted by a small group of relevant staff. For more complex incidents and those with serious consequences, analysis may require a longer meeting and discussion among experts from different departments, chaired by the hospital director or a vice director.
3. In Tu Du Hospital, an intensive root cause analysis (RCA) is conducted if the incident is either (i) a sentinel event, or (ii) related to several departments, or (iii) high chance of recurrence. Usually they organize one RCA meeting every week; each RCA meeting analyzes two incidents. Their RCA meetings are always chaired by the hospital director or a vice director, and always involve representatives from QMD, General Planning Department, and Nursing Department, besides relevant departments.

7. Preventive measures

Tu Du Hospital found that 90-95% of their reported incidents were due to systematic errors. 80% were due to miscommunication. Then they often employ three preventive measures as follows:

a. Adjust procedures;

b. Organize trainings and provide information for hospital staff;

c. Provide warnings to hospital staff

8. Sharing lessons and confidentiality

1. After analyzing incidents, one important activity is to summarize lessons learnt and share with hospital staff. Lessons learnt should be shared as anonymous stories to (i) protect reporters and (ii) avoid possible public/ media pressure due to misunderstandings.
2. Lessons learnt can be shared via newsletters, intranet, etc.

Session 2-1

Initial Results of Implementing Incident Reporting System in Quy Hoa National Leprosy and Dermatology Hospital

Nguyen The Toan

General Planning Department, Quy Hoa National Leprosy and Dermatology Hospital

INTRODUCTION

Necessity of establishing an incident reporting system in the hospital

1. Necessity of establishing an incident reporting system (IRS)

Healthcare is a high-risk environment, where medical errors can occur any time from diagnosis to treatment. It can be certain that every step of examination and treatment contains risks to patients. Moreover, physicians in healthcare settings are constantly under pressure due to overwork and psychological stress. Therefore, adverse events are unavoidable and sometimes out of control. When adverse events happen, both doctors and patients are victims. Especially, affected patients suffer consequences influencing their health, temporary or permanent disabilities, or even death.

2. Rationale for establishing a hospital QM system

- Circular no. 19/2013/TT-BYT dated July 12, 2013 by the Minister of Health guiding QM of examination and treatment in hospital;

- Decision no. 4858/QD-BYT dated December 3, 2013 by the Minister of Health issuing hospital quality standards.

PART ONE

Actual state of the hospital's IRS

Hospital has been following regulations on reporting errors/incidents. There are checklists in operation theaters and procedure rooms; regulations on checking drugs before distributing to patients; checking technical procedures to avoid serious errors/incidents happening to patients. However, error/incident management was not systematic. there were no voluntary reports, cause analysis, and proposed solutions to minimize errors/incidents. For this reason, we have established an IRS in Quy Hoa National Leprosy and Dermatology Hospital as follows:

- Decision on establishing a system to report, summarize, analyze, and fixing medical and other professional errors/incidents in the hospital;

- Regulations on reporting medical and other professional errors/incidents;

- Procedures for recognizing, handling, and reporting medical errors/incidents;

- Incident reporting form;

PART TWO

Initial results of inplementing IRS

After establishing the IRS in August 2016, the hospital conducted trainings for head nurses of departments, who are members of the IRS. Since then, there have been three reports.

Comments:

- The IRS must include a member of the Directing Board to preside and push implementation.

- In weekly meetings of managers, hospital leaders encourage staff and chiefs of departments to report incidents.

- No punishment when incidents occur.

PART 1: CONTENTS OF THE INCIDENT REPORT

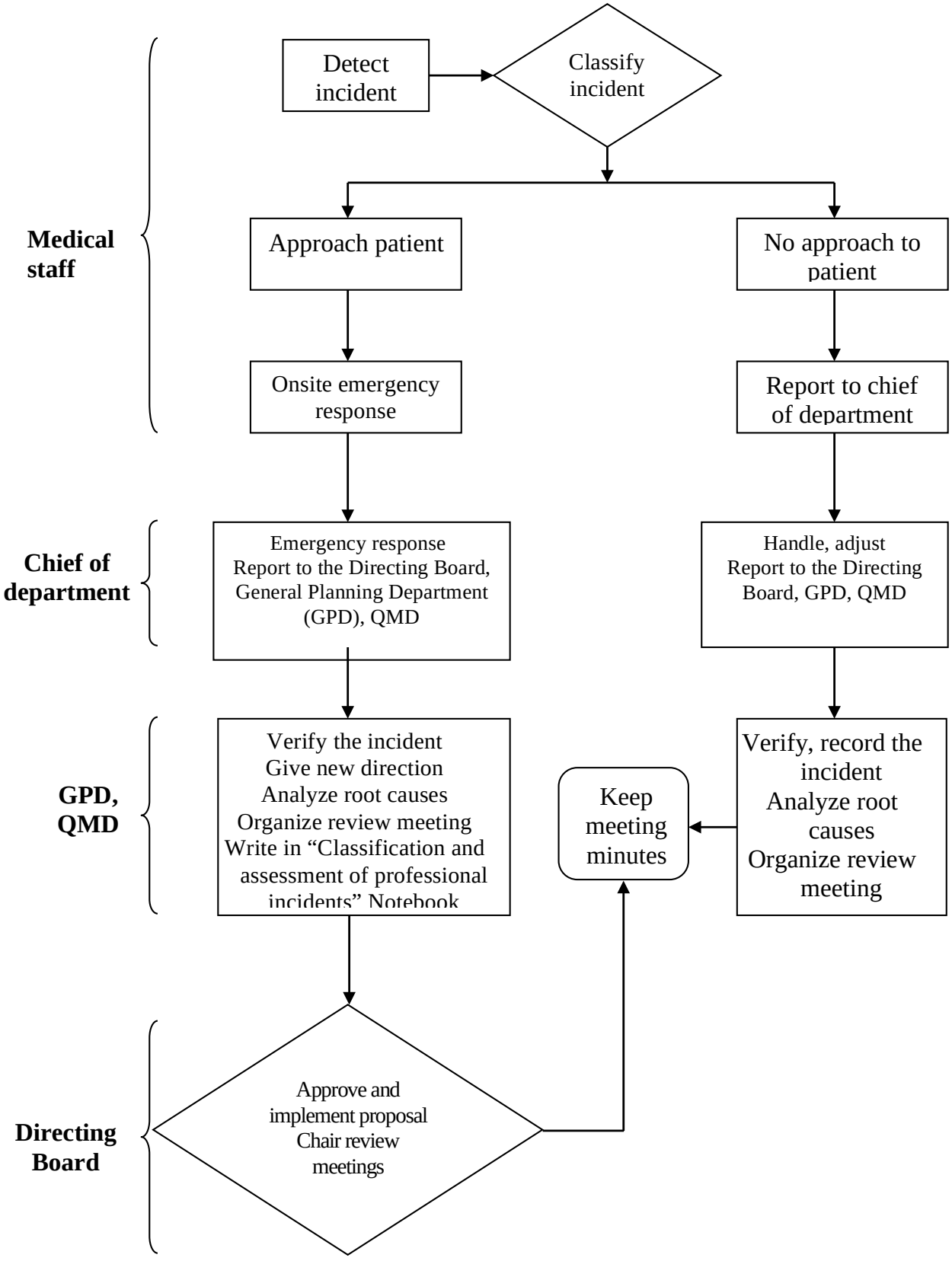
Reporter	**Affected person**	
This item can be skipped.	Full name:	
Full name:	Position:	☐ Healthcare worker
Title:		☐ Patient
Department:		☐ Patient family
		☐ Other:……..
Time of incident	**Venue of incident**	
Date, time of report:	*(Please write down specific bed, ward, department.)*	
Date, time incident occurred:		

Briefly describe incident
Consequences *(at present and expected in the future)*
Immediate response

WAYS TO REPORT	**WAYS TO RECEIVE FEEDBACK**
1. Send/call directly to Quality Management Department ***(Mobile: 0905186525)***	1. Via phone: ……
2. Email to: baocaosuco.bvqh@gmail.com Or LAN: \\192.168.1.115→ Common data of 2 networks → General Planning Department → Baocaosuco	2. Via document: …….. ***Note:*** Please write down telephone number/email/address to receive feedback document.

PART 2: FORM FOR STAFF OF QUALITY MANAGEMENT DEPARTMENT

Type of incident	1. Near miss						
	2. Variance						
	3. Sentinel event						
Level of harm to patient	0	1	2	3a	3b	4	5
Fields related to incident							
1. Examination and treatment procedures	6. IT system						
2. Professional errors, medical incidents	7. Medical equipment and materials						
3. Safety in drug use	8. Security, fire safety						
4. Infection control	9. Accident, fall						
5. Medical record	10. Others: …….						
Root cause analysis							
Solutions *(improvement actions)*							
❖ Short-term							
❖ Long-term							
Monitoring improvement actions and evaluating *(their effectiveness)*							


Medical staff
Detect incident
Classify incident
Approach patient
No approach to patient
Onsite emergency response
Report to chief of department
Chief of department
Emergency response
Report to the Directing Board, General Planning Department (GPD), QMD
Handle, adjust
Report to the Directing Board, GPD, QMD
GPD, QMD
Verify the incident
Give new direction
Analyze root causes
Organize review meeting
Write in "Classification and assessment of professional incidents" Notebook
Keep meeting minutes
Verify, record the incident
Analyze root causes
Organize review meeting
Directing Board
Approve and implement proposal
Chair review meetings

MINISTRY OF HEALTH
QUY HOA NATIONAL LEPROSY - DERMATOLOGY HOSPITAL

INITIAL RESULTS OF IMPLEMENTING INCIDENT REPORTING SYSTEM IN QUY HOA NATIONAL LEPROSY AND DERMATOLOGY HOSPITAL

Presenter: Dr. Nguyen The Toan, MD, PhD

Da Nang, September 2016

2. Actual state of the IRS

- Hospital has reports on errors/incidents:
  - Using checklists in operation theaters and procedure rooms
  - Regulations on checking drugs before distributing to patients
  - Checking technical procedures
- Limitations:
  - No separate system to manage errors/incidents
  - No voluntary reports
  - No reports assessing errors/incidents
  - No analyses of patterns and causes of errors/incidents; no proposed solutions to minimize errors/incidents

Contents

1. Necessity of establishing an IRS in the hospital
2. Actual state of the IRS
3. Establishment of the IRS
4. Results of implementation

3. Establishment of the IRS

IRS in Quy Hoa National Leprosy and Dermatology Hospital

- Regulations on reporting medical and other professional errors/incidents
- Procedures for recognizing, handling, and reporting medical errors/incidents
- Incident reporting form

Decision on establishing a system for reporting, summarizing, analysing, and fixing medical and professional errors/incidents in the hospital

1. Necessity

Error prone environment

Healthcare environment

- Examination & treatment procedures
- Diagnosis
- Treatment
- Working pressure
- Psychological pressure
- Overwork

Serious consequences for patients and doctors

Incident reporting system

Incident Reporting Form

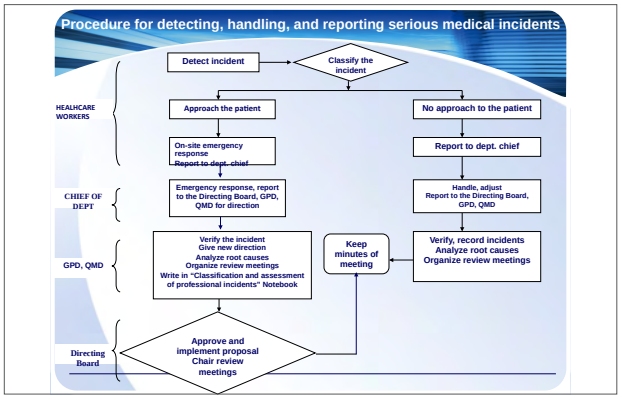
Reporter	Affected person	
This item can be skiped	Full name:	
Full name:	Position:	Healthcare worker
Title:		Patient
Department:		Patient family
		Others:……
Time of incident	**Venue of incident**	
Date, time of report:	*(write down specific bed, ward, department)*	
Date, time incident occurred:		
Describe incident briefly		
Consequences *(at present and expected in the future)*		
Immediate response:		
WAYS TO REPORT	**WAYS TO RECEIVE FEEDBACK**	
1.Send/call directly to Quality Management Department *(Mobile number: 0905186525)*	1. By phone: ……	
2. Email to: baocaosuco.bvqh@gmail.com Or LAN: \\192.168.1.115→ Common data of 2 networks → General Planning Department → Baocaosuco	2. By document: ……	
	Note: Write down phone number/email/ address to receive feedback document	

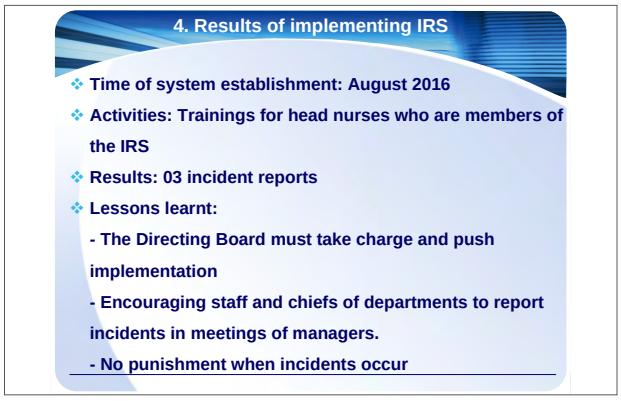
Rationale for establishing the incident reporting system (IRS)

- Circular no. 19/2013/TT-BYT dated 12/07/2013 by the Minister of Health guiding quality management of examination and treatment in hospitals
- Decision no. 4858/QD-BYT dated 03/12/2013 by the Minister of Health issuing Hospital Quality Standards

FORM FOR STAFF OF QUALITY MANAGEMENT DEPARTMENT

Type of incident	1. Near miss						
	2. Variance						
	3. Sentinel event						
Level of harm to patient	0	1	2	3a	3b	4	5
Fields related to incident							
1. Examination and treatment procedure	6. IT system						
2. Professional errors, medical incidents	7. Medical equipment and materials						
3. Safety in drug use	8. Security, fire safety						
4. Infection control	9. Accident, fall						
5. Medical record	10. Others:……						
Root cause analysis							
Solutions *(improvement actions)*							
Short-term							
Long-term							
Monitoring improvement actions and evaluating *(their effectiveness)*							


Procedure for detecting, handling, and reporting serious medical incidents
Detect incident
Classify the incident
HEALHCARE WORKERS
Approach the patient
No approach to the patient
On-site emergency response
Report to dept. chief
Report to dept. chief
CHIEF OF DEPT
Emergency response, report to the Directing Board, GPD, QMD for direction
Handle, adjust
Report to the Directing Board, GPD, QMD
GPD, QMD
Verify the incident
Give new direction
Analyze root causes
Organize review meetings
Write in "Classification and assessment of professional incidents" Notebook
Keep minutes of meeting
Verify, record incidents
Analyze root causes
Organize review meetings
Directing Board
Approve and implement proposal
Chair review meetings


4. Results of implementing IRS
Time of system establishment: August 2016
Activities: Trainings for head nurses who are members of the IRS
Results: 03 incident reports
Lessons learnt:
- The Directing Board must take charge and push implementation
- Encouraging staff and chiefs of departments to report incidents in meetings of managers.
- No punishment when incidents occur


Some pictures of activities


THANK YOU VERY MUCH!

Session 2-2

Failures in Operating Incident Reporting and Management System

Phan Anh Phong[1], Tran Thi Ngoc Hoa[2]

1. Vice Director, Ha Nam Provincial General Hospital
2. Quality Management Department, Ha Nam Provincial General Hospital

1. Reasons for choosing the topic

Ha Nam Provincial General Hospital established a medical incident reporting and management system in August 2015 to help the hospital control medical incidents happening in hospital in terms of level, quantity, ratio, frequency, causes… and therefore give feedback, warnings and solutions to minimize them.

2. Implementation plan

1. Providing information and training on the benefits of reporting medical incidents to all hospital staff;
2. Designing the reporting form, developing consistent procedures for reporting and handling reports;
3. Establishing the reporting system;
4. Implementation.

3-a. Current state

1. Key hospital staff - the Directing Board, chiefs and vice chiefs of departments, head nurses (1/6 hospital manpower) – have received information and training on the benefits of reporting medical incidents. The hospital director shows interest.
2. The reporting form was designed and procedures for reporting and handling reports developed.
3. The incident reporting system was established.
4. Implementation: we receive an average of 5 reports per month. Most of them are mandatory reports or come from issues discussed in professional meetings.
5. After reports are received, root cause analyses are conducted, then feedback is given, and three SOPs have been developed: SOP for blood transfusion, SOP for taking and sending samples, and SOP for sending severe patients for intervention procedures.
6. 6A seminar on promotion of incident reporting and management system was organized in July 2016.

3-b. Objectives

- 1-2 incident reports are received every day.

- A book documenting medical incidents in the hospital is made.

4. Causes analysis

- The biggest obstacle is that staff hesitate to report, daren't to reveal their mistakes, and are afraid of punishment.

- Focal people of the system are passive, not active.

5. Solutions and actual implementation

- The Directing Board and key staff received information. However, only few have changed their perceptions.

- The incident reporting system and relevant procedures were established. However, the system is not operating as effectively as expected.

- There is positive feedback to received reports.

6. Effectiveness and solutions

- Only some mandatory reports yet positive feedback have been received. Therefore, it is necessary to strengthen communication and training, encourage focal points to be more active, analyze causes of reported incidents, protect reporters, and give feedback and warnings so that people recognize the benefits of reporting.

7. Solutions to maintain and develop the system

- Maintaining the director's interest.

- There must be a staff in charge, who has knowledge on incident reporting system and is enthusiastic.

- Encouraging focal people to work actively.

-Being active in communication, training, and proving the system's effectiveness.

8. Lessons learnt

- It is not difficult to establish an incident reporting system.

- It is not simple to make the system work effectively and bring benefits. It requires enthusiasm, patience and activeness.

Session 2-3

The Incident Management Journey in Tu Du Hospital

Tran Nguyen Nhu Anh

Quality Management Department, Tu Du Hospital

In the 5-year journey (from 2011 to present), with the commitment and determination of leaders and staff, our Tu Du Hospital has built a safety and quality culture, expecting that **"Good hospital becomes better"**. We act together with a belief in victory and overcoming ourselves so that "today is better than yesterday".

We understand deeply that there are many things to do for a safe and quality healthcare environment. As Professor Domingo, a quality expert, said "Hospital is a perfect environment to create errors" and "To err is human", people make mistakes because "No one is perfect". Perhaps all healthcare workers before their first step in the healthcare career feel very proud, moved, and determined to fulfill the Hippocratic Oath "First do no harm". No one working in healthcare wants to harm patients; therefore, errors or incidents (if any) happen because there are too many risks and traps surrounding us, as if they are waiting for their "opportunity". So what should we – all hospital staff – do to develop a safer and better quality environment for ourselves?

With these perceptions and messages, we develop and standardize an incident management procedure. Staff share their perspectives, high-risk factors, their incidents and errors or those of their colleagues by reporting incidents to QMD. Then, the staff in charge in QMD sets up a GO–SEE group to study the details of the incidents. What actually happened? After that, we meet with relevant departments to study the root causes and propose appropriate solutions. Later, we implement the solutions and evaluate their effectiveness. All these activities follow the PDCA cycle. PDCA cycles keep going one by one in a journey that has a starting point but no end.

Besides, we provide information of these stories – incidents, causes, ways for improvement – to all 35 departments via Safety Newsletter, LAN, or hospital grand meetings. Every such activity always goes with the mottos "One's incident is a lesson for someone else", "Prevent incidents from repeating", or "Keep moving forward".

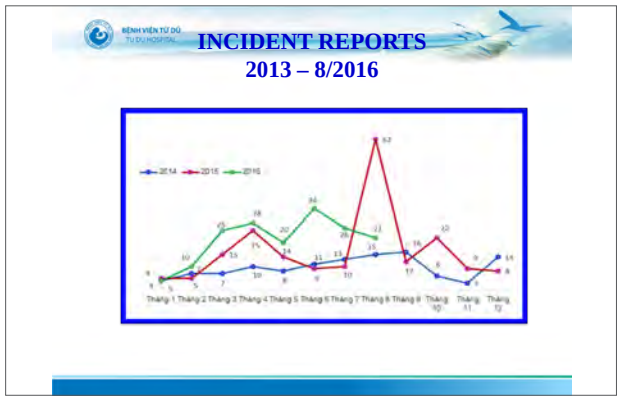
Managing incidents in the hospital with 2,500 staff and 1,900 actual beds, we deeply understand the challenging path we are taking with blaming culture, punishment culture, and collective silence culture standing in the way to trust, safety culture, and quality culture. We have made breakthroughs in creating a PS playground. For example, "The Way to the Olympia Peak" gameshow format is employed in our training courses on incident management with **laughter** filling the hall. We introduce active teaching, learner-centeredness, **group work, connection, love, and alliance** to attract people to seemingly dry QM/PS activities. In all activities, we always encourage, praise, and reward groups with good results as well as set criteria to honor well-implementing departments.

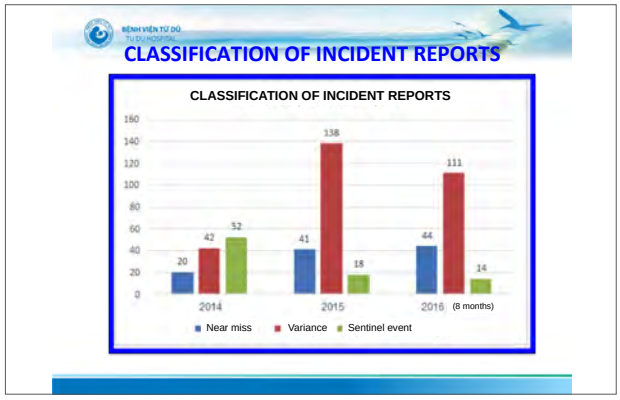
From glamourous activities, we gradually grow deeper by working effectively to meet what departments expect when they report incidents: we DO what we SAY. When trust is built, people gradually BELIEVE and accompany us. Besides, with issues we are not able to handle at the moment, we always share information, explain why it is not possible at this moment, and ask for their sympathy. With information shared and with our efforts, our colleagues show sympathy and keep accompanying us.

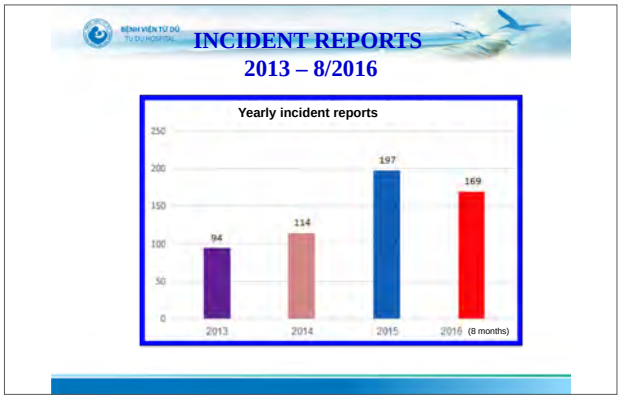
Our successes have been supported by the Directing Board by soft skill training courses such as "Change management – team building", "Personal skills development", and "Understand ourselves – accompany patients", which promotes understandings **"who am I; what is my mission?"** as well as **"what values do I bring to myself and others?"** Self-understanding

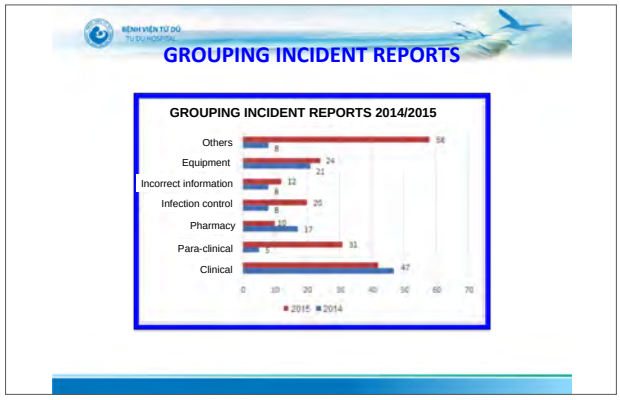
helps materialize ourselves in our work, interact well with ourselves, balance work and family, interact better with patients and colleagues, and devote ourselves to work. Programs such as “Process map”, “Job instruction”, and “Mistakes proofing” also help building a safer environment. Yes, each individual becomes a change agent to make our life better. And when healthcare workers are happier in their life, their work will be more effective and patients will be happier.

TRUST – LOVE – CONNECTION – INFORMATION SHARING - SYMPATHY have created an environment where we – hospital staff - **love and belong**. We have been holding our hands and work together from one single incident on the first day operating the system (despite high prize) to more than 500 voluntary reports at present. The spirit of incident reporting is highly appreciated because it helps create a safer healthcare environment for ourselves and patients, our special clients.

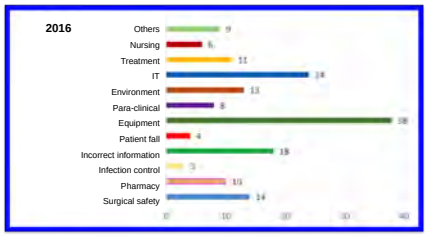


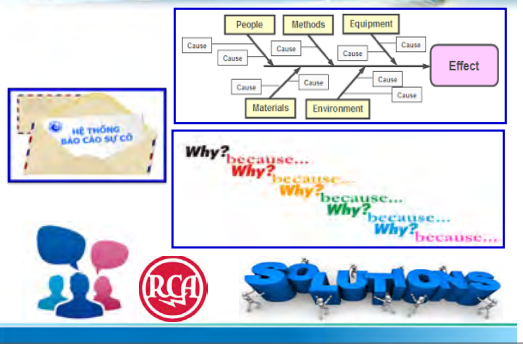




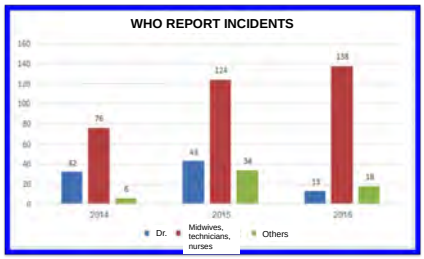


GROUPING INCIDENT REPORTS

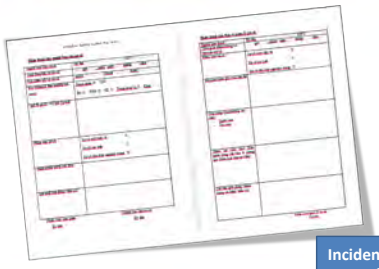




REPORTERS



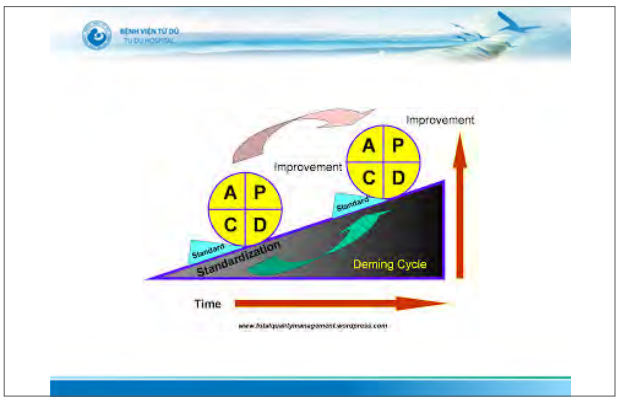
INCIDENT REPORTING



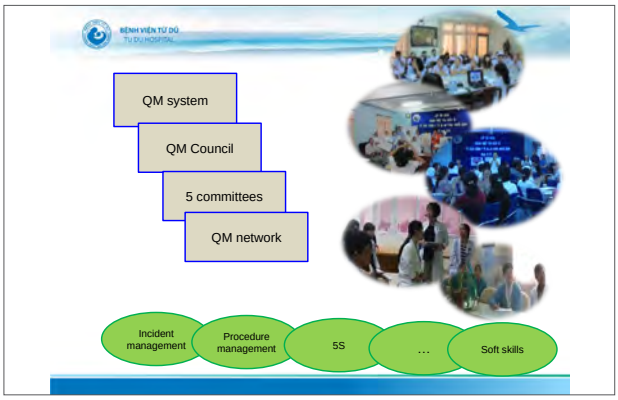
Incident reporting form

INCIDENT REPORTING


WARNING


Improvement
A P
C D
Improvement
A P
C D
Standard
Standardization
Deming Cycle
Time


speak out
Patient Safety Newsletter


QM system
QM Council
5 committees
QM network
Incident management
Procedure management
5S
…
Soft skills


speak out
Patient Safety Newsletter


2011


DO NOT THINK THAT
"I WILL NEVER BE LIKE THIS"
REALITY-TV

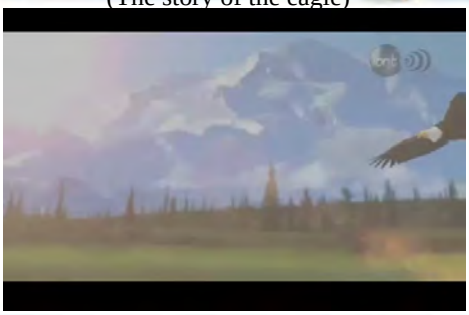

2012
QUẢN LÝ CHẤT LƯỢNG
Băng Huyết Sau Sanh
QUY TRÌNH XIN MÁU
NGÂN HÀNG MÁU


2013
TẬP HUẤN
BÁO CÁO SỰ CỐ
PHÂN LOẠI - QUI TRÌNH BÁO CÁO SỰ CỐ

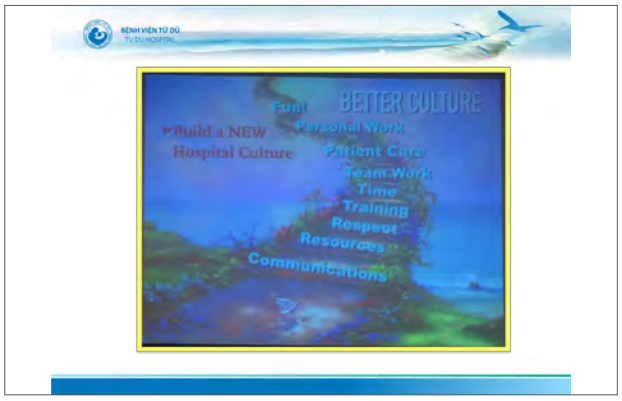

2015

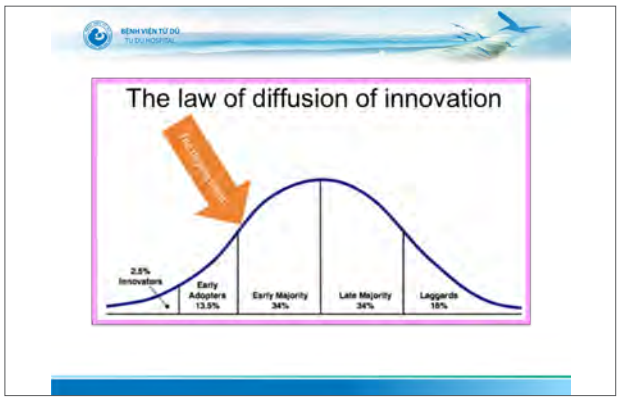

2014
HOẠT ĐỘNG CTCL 2014
HOẠT ĐỘNG CTCL 2014

(The story of the eagle)




Thank You!


BETTER CULTURE
Build a NEW Hospital Culture
Time
Training
Respect
Resources
Communications


The law of diffusion of innovation
2.5% Innovators
Early Adopters 13.5%
Early Majority 34%
Late Majority 34%
Laggards 16%

Session 3 Signboards in Hospital

Summary of Discussion

1. Necessity

1. Indicator A1.1 in MOH's Hospital Quality Standard assess whether "patients are clearly instructed, well received and logically and specifically guided". A good hospital signboard system can provide helpful instructions for patients to navigate easily in the hospital.
2. Difficulties in navigation in the hospital contribute to patients' dissatisfaction. A helpful signboard system can help increase patient satisfaction.

2. The Roles of QMD in Improving Hospital Signboard System

1. In many hospitals in Vietnam, the Administration Department is in charge of managing the hospital signboard system. QMD can work together with this department to improve the system. In Thu Duc District Hospital, QMD asked the hospital director for them to take charge of this duty. They still collaborated with the Administrative Department to fulfill the task.
2. Normally QMD works with the administrative department as well as an external design company to develop a system that meet the hospital's needs. QMD should review and study the existing system, then present their ideas of a new system to the design company. Information that QMD needs to collect is a complete list of current signboards (including papers temporarily hung on the wall), different types of signboards, how they are used, contents of each signboard…

3. Implementation

1. Usually a hospital does not change the whole system at the same time. It may take some time to change gradually.
2. Implementation depends on the hospital budget. Usually the design company will provide different options of materials and sizes of signboards with different prices for the hospital to choose.
3. Some hospitals are concerned about English names for departments, since MOH requires that hospital signboards must be in both Vietnamese and English whereas there is no glossary for hospitals to follow. Thu Duc District Hospital learnt from the naming systems of UK's National Health Services (NHS) and some hospitals in USA and Taiwan. In addition, some doctors who had years of experience working in a hospital abroad helps name departments in English.
4. While a hospital may adopt a leading color for their signboard system (e.g., sky blue in Thu Duc District Hospital), they should follow some universal principles such as using red color for emergency. Scientific research shows that red is a top eye-catching color, so it is usually used for emergency cases.
5. Some hospitals, such as Bach Mai Hospital, are implementing Corporate Identity Program so their signboards follow some designing rules under this program.
6. Hospitals in Vietnam are often required to put some health communication posters on the wall but when such communication posters are put beside the hospital signboard, it looks like the hospital is less professional. Therefore, some hospitals put separate bulletin/information boards to hang these posters.
7. There can be different ways to number patient beds, but normally it should be from left to right, up to down according to one's common way of reading in Vietnam.

Session 3

Experience in Improving Hospital Signboard System

Huynh My Thu, Hoang Thi Oanh, Hoang Thai Phi Long, Tu Huynh Hoang Tu, Nguyen Thi Nhuan
Quality Management Department, Thu Duc District Hospital

1. Reasons for choosing the topic

Thu Duc District Hospital is a 1st level general hospital located in the northeast of Ho Chi Minh city, with 800 inpatient beds, 3,500–4,000 turns of outpatients per day. There are more than 1,200 staff, young and active. With limited facilities undergoing many renovations and crowded flows, provision of information and guidance for patients, patient family members, and visitors is one of the core tasks to improve the quality of examination and treatment, reduce moving time, and increase patient satisfaction.

2. Targeted users

- People who visit the hospital the first time for examination and treatment;

- Patients who came to the hospital before but change their departments of visit (2nd time or more);

- Patient family members;

- Visitors or business partners;

- New healthcare workers who do not know well how to navigate the hospital.

3. Implementation plan

NO.	ACTIVITIES	TIME
1	Make detailed action plan	Week 3 - July 2016
2	Calculate the number of signboards needed	Week 4 - July 2016
3	Identify positions, quantity, and sizes needed	Week 4 - July 2016
4	Design standard signboard of each type	August 2016
5	Collect comments and generate consensus	Week 1 - August 2016
6	Ask the designer to complete	Week 2 - September 2016
7	Approve and confirm the designed boards	Week 3 - September 2016
8	Adjust (if necessary)	Week 4 - September 2016
9	Report progress	Week 4 - September 2016

4. Actual state

An outpatient survey in Thu Duc District Hospital in Quarter 1 of 2016 shows that only 65% were satisfied with the signboards.

5. Cause analysis

- The signboard system was not systematic and consistent.

- Many boards are temporarily placed in inappropriate positions.

- The colors were not eye-catching and attractive to readers.

6. Objective

Provision of information and instructions in the hospital is improved, with more than 70% of hospital visitors understand and know how to navigate in the hospital.

7. Action plan

Review documents; visit and learn about the design and installation in some hospitals;

Based on the hospital's infrastructure, design some sample signboards and consider their suitability;

Assign a focal person for management; ban temporarily hung boards; boards contents must be sent to QMD for approval;

Collect comments on draft and complete designs from hospital leaders and departments.

8. Results

9. Difficulties and solutions

a. Difficulties

- Designs of signboards were not attractive and informative enough to readers.

- Designing and installation of signboards in the hospital met many difficulties such as too many contents in a signboard, difficulty in management and calculation, unsystematic and inconsistent placing of signboards;

- The buildings in the hospital are very close to one another, so visitors may find it difficult to identify their venue if they follow the signboards without checking the map.

b. Solutions

- Attract readers by mixing color in consideration of light, contrast, using easy-to-read pastel colors (the key colors are blue, orange yellow, white and brown, except the maps depending on building colors, which may include other colors besides the four key colors). The signboards include both English and Vietnamese, as well as icons for illiterate people and those with eyesight problems.

- In places that have so many things to guide, install a number of signboards where necessary; or first put the name of the main technique, then those of the specific ones.

- Instructions are given by block. Each block must have its name board and its own color. Signboards and maps are designed for each block and use the block's color. All must use symbols, have specific size, and be installed at least 1.2m above the ground.

- Show the position of the reader in all the maps in the hospital with detailed explanation.

EXPERIENCE IN IMPROVING HOSPITAL SIGNBOARD SYSTEM

HUYNH MY THU, MSc.
CHIEF OF QUALITY MANAGEMENT DEPARTMENT
THU DUC DISTRICT HOSPITAL, HO CHI MINH CITY

2 CONTEXT

- 1st level hospital
- 10 functional departments and 36 departments
- 800 INPATIENT beds
- Outpatient: 3,500 – 4,000 visits/day
- Manpower: 1,280 staff (31/12/2015)

3 TARGETED USERS

- Patients, patient family members
- Visitors
- New staff

4 IMPLEMENTATION PLAN

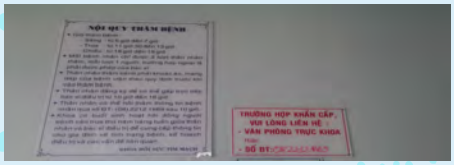
NO.	CONTENTS	TIME
1	Make detailed action plan	Week 3 - July 2016
2	Calculate the number of signboards needed	Week 4 - July 2016
3	Identify positions, quantity, and sizes needed	Week 4 - July 2016
4	Design standard signboard of each type	August 2016
5	Collect comments and generate consensus	Week 1 - August 2016
6	Ask the designer to complete	Week 2 - September 2016
7	Approve and confirm the designed boards	Week 3 - September 2016
8	Adjust	Week 4 - September, Week 1 October 2016
9	Report	Week 2 – October 2016

5 ACTUAL STATE

An outpatient survey in Thu Duc District Hospital in Quarter 1 of 2016 shows that only 65% were satisfied with the signboards.

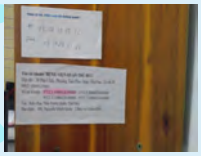
6 CAUSES

- The signboards were not systematic and consistent.



7 CAUSES

- Many signboards were placed temporarily in inappropriate positions, causing difficulties in management and calculation.



8 CAUSES

- The colors were not eye-catching and attractive to readers.

9 AIM

1. Reader oriented and reader centered
2. Highly aesthetic, easy to see, and easy to read sign board system
3. Suitable to different hospital visitors
4. Shorten time for moving between areas
5. Easy for management and adjustment when there are changes or damage.

10 OBJECTIVE

Provision of information and instructions in the hospital is improved, with more than 70% of hospital visitors understand and know how to navigate in the hospital.

11 Action plan

- ❖ Review documents; visit and learn about the design and installation in some hospitals;
- ❖ Design some sample signboards and consider their suitability;
- ❖ Assign a focal point for management, ban temporarily hung boards, boards contents must be sent to QMD for approval;
- ❖ Collect comments on draft and complete designs from hospital leaders and departments.

12 TYPES OF HOSPITAL SIGNBOARDS

a. Map
b. Organizational chart
c. Direction board to areas/blocks and departments
d. Department name board
e. Information board, rules and regulations board
f. Nameplates of healthcare workers

13 Font

- **Bold monospaced lowercase** (Arial, Tahoma...)
- **First letter capitalized**

Pharmacy

- **Proportional text (Time New Roman, VNI-Times...)**
- **Text that is italic, too bold, or shaded**

Pharmacy

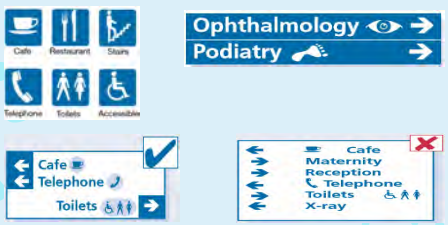
14 Contents

- ❖ **No more than 5 destinations in a signboard (grouping the areas, simplifying)**
- ❖ **Information must be clear, easy to read, visualized, and vivid**
- ❖ **Boards should show functional areas and directions systematically and logically**
- ❖ **Standardize margins**
- ❖ **Insert space between lines**

15 Colors

- ❖ **Contrast colors**
- ❖ **Red background, white characters: urgent status**
- ❖ **Avoid too many colors**

16 Symbols

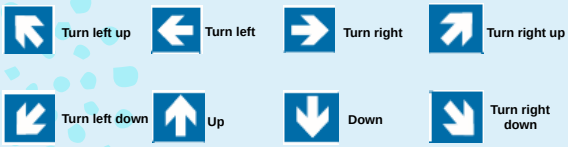


17 View

2m

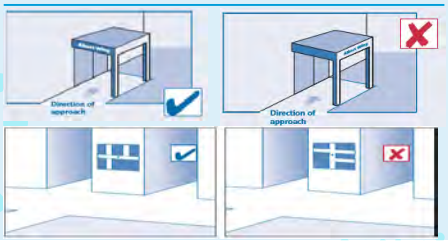
1m2

18 Arrows



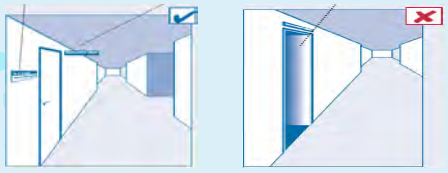
19 Positions

❖ Boards should follow the direction of approach

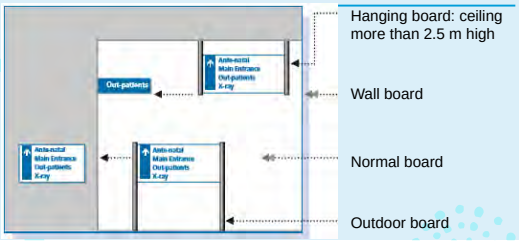


20 Positions

❖ Boards should be hung on the left wall of the door or within the reader's view
❖ Do not hang above the door

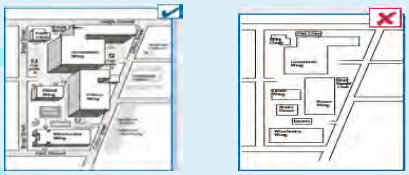


21 Positions



22 Maps

❖ Not detailed enough
❖ No street names
❖ No entrances shown
❖ The reader's position not identified (no "you are here")



23 RESULTS

Examination procedure for outpatients with health insurance

Emergency light box

24 RESULTS

Maps

25 RESULTS

Direction boards

26 RESULTS

CONCLUSIONS

1. Results are changes
2. Good → standardize
3. Not good → PLAN

ACT — PLAN

1. 5 W 1 H – 2 C – 5 H
2. PEST analysis

SOLVING PROBLEM

1. Audit, inspection…
2. Evaluate results.

CHECK — DO

1. Pilot implementation
2. Analysis
3. Solutions
4. Indicators
5. …

THANK YOU

Session 4 How to Ensure Quality and Safety in Clinical Work?

Summary of Discussion

1. Application of Surgical Safety Checklist (SSC)

1. A number of hospitals in Vietnam have been applying WHO SSC (with modifications) to enhance their surgical safety, under the leadership of QMD (e.g., Ha Tinh Provincial General Hospital, Hue Central Hospital) or General Planning Department (e.g., Bach Mai Hospital).
2. Some hospitals may need to modify WHO SSC for easier and better application in their contexts. In such cases, pilot implementation and feedback from practitioners (surgeons, anesthetists, nurses, technicians and other staff involved in surgery work) is helpful. Ha Tinh Provincial General Hospital involved practitioners when modifying the checklist and discussing how to use it. This resulted in high compliance of application of SSC.
3. Generally, modifications should only add more necessary contents to the original SSC and should not remove any original contents. Some practical modifications in Vietnamese hospitals include:
    a. Hue Central Hospital specifies the checklist on which checks should be done by whom, and the surgeon's parts are colored.
    b. Ha Tinh Provincial General Hospital assigns the anesthetist to take charge of filling the checklist, which works better than assigning this task to a nurse previously. When a nurse was in charge of this task, some doctors were not cooperative.
    c. The surgeon, the anesthetist, and the scrub technician/nurse are required to sign and give full name at the bottom of the checklist. In Ha Tinh Provincial General Hospital, the surgeon is required to check lastly and give signature in the checklist.
    d. Some categories of surgery type (program surgery, emergency surgery, major surgery, medium surgery…) are added to the checklist for QMD to collect more data for research and review.
4. Training is necessary for practitioners before applying the checklist. In Bach Mai Hospital, application without trainings resulted in 32% of surveyed staff meeting difficulties in filling the checklist and 93% expressing they need training. In Ha Tinh Provincial General Hospital, QMD organized separate trainings for doctors and nurses/ technicians.
5. It is not easy to convince surgeons who are excellent, highly respected and usually have strong personality to apply the checklist. In Ha Tinh Provincial General Hospital, the head of QMD talked to these surgeons individually about use of the checklist in a soft yet determined manner.
6. One concern for practitioners is time spent for filling the checklist. QMD can measure the time for (i) reduction (improvement) if it's too long and (ii) showing evidence to convince hesitating staff to apply the checklist. In Hung Vuong Hospital, after practice for some time, the average time for filling the checklist is one minute now.
7. Monitoring the compliance is necessary, yet some QMDs hesitate to send staff to the surgery room for its direct monitoring. However, some others managed to do this, e.g., Ha Tinh Provincial General Hospital and Hung Vuong Hospital.
    a. In Ha Tinh Provincial General Hospital, at the beginning, the head of QMD, who is also a surgeon himself, performed this task and gradually train his QMD staff, who are not surgeons, to do the job. It is important that QMD staff shows that their presence is not only to supervise the operating team but more about checking how the checklist is applied in reality, whether there are difficulties for practitioners, and looking for improvement opportunities. QMD staff usually discuss with the operating team about application of the

checklist right after the surgery. QMD staff came to monitor the operating team and receive a lot of helpful feedback to improve the checklist as well as its application.

b. In Hung Vuong Hospital, the monitoring team are carefully trained for the job and required to attend the surgery from the beginning to the end. They also developed a separate checklist to check compliance to the SSC. This checklist is different from the SSC. The presence of QMD staff in the surgery room is also important to promote the operating team to comply to the SSC, especially at the beginning.

8. One participant proposed using camera for monitoring the surgery without sending monitoring staff to the surgery room. However, this practice is not common. In some hospitals, including those in Japan and some in Vietnam, although cameras are installed in surgery rooms they are mostly for education and consultation, not for monitoring. One doctor expressed ethical concern about using camera for monitoring.

9. An indirect way to check compliance to SSC is checking the checklist that had already been filled, preferably after the patient's moving to the postoperative room and before sending their medical record including the checklist to General Planning Department. Bach Mai Hospital and Hue Central Hospital apply this practice. Although the check may involve errors, such as the operating team may check what they did not perform or not check what they did perform, this data analysis may still reveal some improvement opportunities, such as the items practitioners tend to skip most.

10. There are two different thoughts about applying the SSC in emergency surgeries. Some think that it is acceptable to skip filling the SSC in emergency cases. For example, some patients in critical situations who were transferred directly from Emergency Department to Surgery Department must be and in fact were operated right away before their medical records were sent there.

11. However, some doctors and data show that it is easier to commit mistakes in emergency surgeries than in non-emergency surgeries. Therefore, hospitals should think about how to apply the SSC without affecting specific requirements of emergency surgeries.

12. Although most people agree that elective surgeries should apply the SSC, some are concerned about whether the surgery can go on if the operating team refuse to apply the SSC. Some think that in such cases the surgery must be postponed while some others think that the surgeon has the right to conduct the surgery with or without filling the SSC, because what the surgeon receives for not filling the SSC (e.g., punishment) is separate from his/her right to do an operation.

2. Antimicrobial Stewardship

(Mainly from Cho Ray Hospital's experience)

1. In order to encourage doctors to employ antibiotic prophylaxis, in September 2015, Cho Ray Hospital issued a document requiring that all surgeries must assess risks of surgical site infection. The surgery plans without such assessment or without mentioning about use of antibiotic prophylaxis will not be approved. QMD monitors this practice by sending staff to a surgery approval meeting and having medical records checked by clinical pharmacists.

2. Doctors are usually concerned about surgical site infection if they do not prescribe antibiotics after the surgery. Therefore, QMD measures surgical site early infection rates and found that even if doctors employed antibiotic prophylaxis or doctors did not prescribe antibiotics after surgery, surgical site early infection rates did not increase.

3. Beneficiaries of reducing unnecessary antibiotics after surgery include: patients, medical insurance agencies, communities (due to decreased antimicrobial resistance), and pharmacy companies as well. In the short term, they would sell less antibiotics but in the long term they can prolong the lives of the antibiotics they produce.

4. Support from hospital leaders, especially the director, is very important. In Cho Ray Hospital, the hospital leaders show their support not only in words but also in action. For example, they always attend regular meetings of the antimicrobial stewardship program, give comments, and remind staff/departments who have not complied well.

3. QMD's roles in ensuring clinical safety

1. QMD does not produce clinical quality in a hospital. However, they can contribute their part to ensure and

enhance safety in clinical work.

2. Setting short-term S.M.A.R.T objectives is practically helpful because in a short time it can bring results and sense of achievement, which helps motivate staff to keep up with improvement activities.
3. Technically, QMD should measure some necessary indicators to provide evidence for quality improvement opportunities and effectiveness of quality improvement measures, such as time needed for filling the SSC or surgical site infection rates in relation with antibiotic uses. This evidence will help convince other departments as well as the leaders to support and comply to safety practices.
4. Knowing how to work with other departments is essential. QMD may meet resistance from clinical departments, but they should express a cooperative attitude instead of opposing attitude, supporting instead of fault-finding. If clinicians do not comply to a safety practice, QMD should first check whether the practice is convenient and feasible for application.
5. Sharing information of improvement projects progress and results to collaborators from other departments is helpful because it makes everyone feel they are part of the project. The project results should be presented as achievements of everyone, not those of QMD alone.
6. Providing safety trainings to clinical staff is helpful. However, it is not easy to attract them to such trainings. An experience in Cho Ray Hospital was organizing trainings before the day many staff had an exam/test. In such case, they attended more and even recorded the lecture for self-study later.

Session 4-1

Surgical Safety in Bach Mai Hospital

Nguyen Thi Huong Giang

Quality Management Department, Bach Mai Hospital

1. Reasons for choosing the topic

Medical errors, especially those related to surgery and procedure, not only affect surgical quality but also prolong treatment and hospitalization, decrease patients' income, increase treatment cost, morbidity and mortality rates, patients' pains, denunciations and legal problems.

Medical incidents related to surgery and procedure are common, which according to some studies account for more than 50% of all incidents. According to Joint Commission International, there were 116 wrong-site surgeries in the United State in 2008. In Viet Nam, big hospitals are always overcrowded with patients and have high work pressure, especially in surgery and anesthesia departments. Many adverse events happen due to mistakes during preparation and control before, during and after surgery. These events can be controlled or minimized if there is a strict controlling process. Surgical safety checklist (SSC) is considered an effective tool to prevent medical incidents and errors related to surgery and procedure in Vietnam's context.

2. Actual state in Bach Mai Hospital

Bach Mai Hospital is a general hospital with 1,900 beds. It has 8 surgery departments: Cardiovascular Surgery, General Surgery, Neurosurgery, Orthopedics, Obstetrics and Gynecology, Ophthalmology, ENT, and Odonto-stomatology. There are 12 operation theaters with 210 staff (including surgeons, anesthesiologists, anesthesia technicians, scrub nurses, nurses, etc.). The hospital performs about 14,000 surgeries a year.

By July 2016, the SSC had not been applied consistently in surgery departments and surgical incidents had not been fully recorded.

In June 2016, a wrong-arm surgery happened in a hospital in Nghe An Province and in July 2016, wrong-leg surgery happened in Viet Duc Hospital. Under such circumstance, the hospital's Directing Board required that all surgery departments apply SSC in operation theaters.

3. Objective

SSC is applied in surgery departments in the hospital in August 2016.

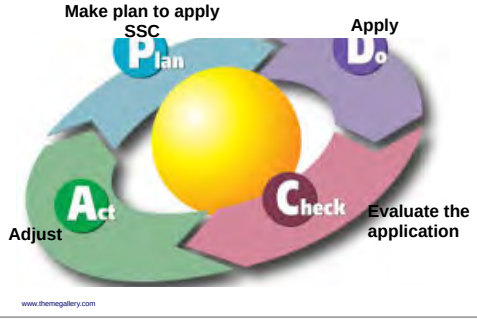
4. Plan

No.	Contents of work	Time							Department in charge
		Jul	Aug	Sep				Oct	
				1/9	15/9	25/9	30/9		
A	Develop SSC								GPD Nursing Department
B	Apply SSC								GPD Nursing Department
C	Evaluation								QMD
1	Develop plan and survey tools								QMD
2	Deliver perception survey forms								QMD
3	Collect data related to the practice from medical records								QMD
4	Report results and propose solutions								QMD GPD Nursing Department
D	Implement solutions								QMD GPD Nursing Department

SURGICAL SAFETY IN BACH MAI HOSPITAL

Nguyen Huong Giang, MD., MSc.
Chief of Quality Management Department
Bach Mai Hospital

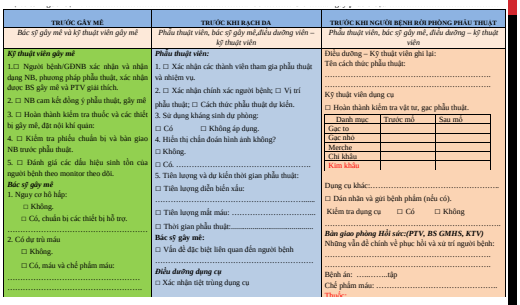
INTRODUCTION OF SSC IN BACH MAI HOSPITAL



INTRODUCTION

- Medical errors, especially surgical ones, not only affect surgical quality but also increase treatment costs and time, complication and mortality rates, patients' pains, as well as denunciations and legal problems.
- Many studies show that using surgical safety checklist (SSC) helps reduce surgical incidents

SSC DEVELOPMENT



TRƯỚC GÂY MÊ *Bác sỹ gây mê và kỹ thuật viên gây mê*	TRƯỚC KHI RẠCH DA *Phẫu thuật viên, bác sỹ gây mê,điều dưỡng viên – kỹ thuật viên*	TRƯỚC KHI NGƯỜI BỆNH RỜI PHÒNG PHẪU THUẬT *Phẫu thuật viên, bác sỹ gây mê, điều dưỡng – kỹ thuật viên*
Kỹ thuật viên gây mê 1.☐ Người bệnh/GĐNB xác nhận và nhận dạng NB, phương pháp phẫu thuật, xác nhận được BS gây mê và PTV giải thích. 2. ☐ NB cam kết đồng ý phẫu thuật, gây mê 3. ☐ Hoàn thành kiểm tra thuốc và các thiết bị gây mê, đặt nội khí quản: 4. ☐ Kiểm tra phiếu chuẩn bị và bàn giao NB trước phẫu thuật. 5. ☐ Đánh giá các dấu hiệu sinh tồn của người bệnh theo monitor theo dõi. ***Bác sỹ gây mê*** 1. Nguy cơ hô hấp: ☐ Không. ☐ Có, chuẩn bị các thiết bị hỗ trợ. 2. Có dự trù máu ☐ Không. ☐ Có, máu và chế phẩm máu:	***Phẫu thuật viên:*** 1. ☐ Xác nhận các thành viên tham gia phẫu thuật và nhiệm vụ. 2. ☐ Xác nhận chính xác người bệnh; ☐ Vị trí phẫu thuật; ☐ Cách thức phẫu thuật dự kiến. 3. Sử dụng kháng sinh dự phòng: ☐ Có ☐ Không áp dụng. 4. Hiển thị chẩn đoán hình ảnh không? ☐ Không. ☐ Có 5. Tiên lượng và dự kiến thời gian phẫu thuật: ☐ Tiên lượng diễn biến xấu: ☐ Tiên lượng mất máu: ☐ Thời gian phẫu thuật: **Bác sỹ gây mê:** ☐ Vấn đề đặc biệt liên quan đến người bệnh ***Điều dưỡng dụng cụ*** ☐ Xác nhận tiệt trùng dụng cụ	Điều dưỡng – Kỹ thuật viên ghi lại: Tên cách thức phẫu thuật: Kỹ thuật viên dụng cụ ☐ Hoàn thành kiểm tra vật tư, gạc phẫu thuật. Danh mục / Trước mổ / Sau mổ Gạc to Gạc nhỏ Mercher Chỉ khâu Kim khâu Dụng cụ khác: ☐ Dán nhãn và gửi bệnh phẩm (nếu có). Kiểm tra dụng cụ ☐ Có ☐ Không ***Bàn giao phòng Hồi sức(PTV, BS GMHS, KTV)*** Những vấn đề chính về phục hồi và xử trí người bệnh: Bệnh án: ……tập Chế phẩm máu: …… Thuốc:

BACH MAI HOSPITAL

Bach Mai is a general hospital with 1,900 beds. It has 8 departments that conduct surgeries: Cardiovascular Surgery, General Surgery, Neurosurgery, Orthopedics, Obstetrics and Gynecology, ENT, Odonto-Stomatology. There are 14 OTs with 210 staff, and about 14,000 surgeries every year.

SSC APPLICATION

- **Organize meetings to develop the checklist**
- **Introduce and apply the checklist**
- **The hospital sent documents to require departments to use the checklist from August 15, 2016**

SURGICAL SAFETY IN OTHER HOSPITALS

ở Nghệ an: Toàn bộ kíp mổ bị kỷ luật

Lãnh đạo Bệnh viện 115 Nghệ An cho biết, đã quyết định đình chỉ công tác một tháng với vị bác sĩ để xảy ra sai sót trên.

- 9 vụ mổ nhầm bộ phận cơ thể người gây rung động Thế giới
- Bác sĩ mổ nhầm chân bệnh nhân có thể bị xử lý hình sự?

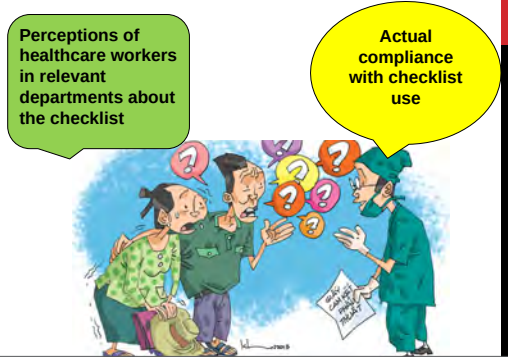
Tin nên đọc

bệnh viện Việt Đức

06:32 ngày 21 tháng 07 năm 2016

TP - GS.TS Trần Bình Giang, Phó Giám đốc bệnh viện, thừa nhận: "Đây là sai sót hoàn toàn từ phía bệnh viện".

EVALUATION OF THE APPLICATION



EVALUATION OF CHECKLIST APPLICATION

- **Venue**: 8 surgical departments that applied the SSC
- **Time**: 16-23/09/2016
- **Evaluation methods**:

+ Evaluation of staff perception: questionnaires sent to staff

+Evaluation of practice: contents of checklists attached to medical records were studied.

- **Subjects**: 103 healthcare workers who involved in surgeries in the 8 departments and 144 medical records of patients who underwent surgeries (records in postoperative rooms)

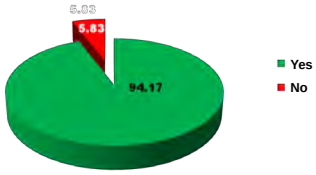
PERCEPTION OF HEALTHCARE WORKERS

Are the contents and division of tasks in the checklist appropriate?

Percentage of appropriateness / Stages	Contents (%)	Division of tasks (%)
Sign in	96.67	97.78
Time out	95.65	95.6
Sign out	97.78	97.78
All stages	96.7	97.05

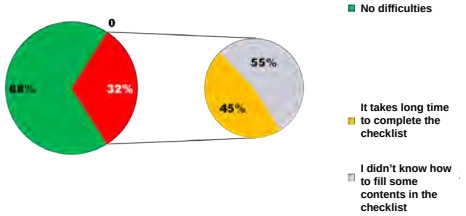
PERCEPTION OF HEALTHCARE WORKERS

Are you aware of the surgical safety checklist?



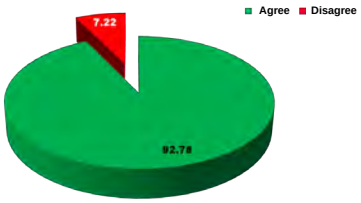
PERCEPTION OF HEALTHCARE WORKERS

Difficulties in applying the SSC?



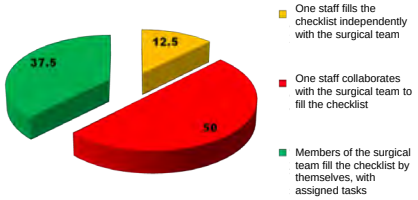
PERCEPTION OF HEALTHCARE WORKERS

Is the SSC really necessary for PS?



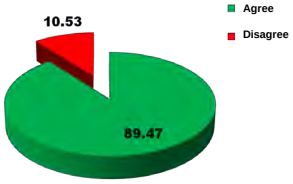
PERCEPTION OF HEALTHCARE WORKERS

The checklist should be filled by?



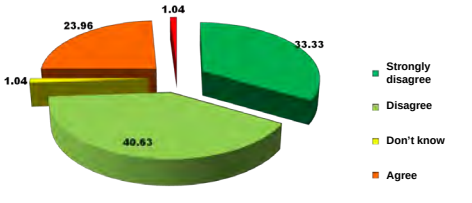
PERCEPTION OF HEALTHCARE WORKERS

Are the surgical phases divided appropriately according to the checklist?

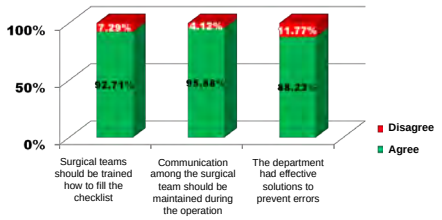


PERCEPTION OF HEALTHCARE WORKERS

The checklist can be filled any time before medical records are sent to the GPD



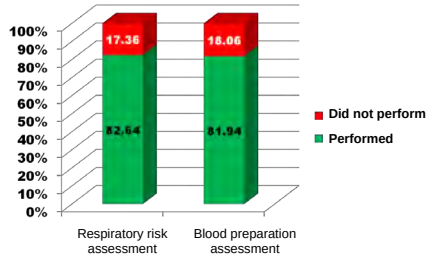
PERCEPTION OF HEALTHCARE WORKERS



EVALUATION OF PRACTICE

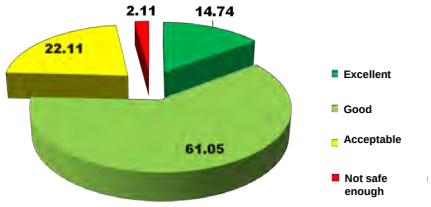
Sign in

Anesthesiologist:



PERCEPTION OF HEALTHCARE WORKERS

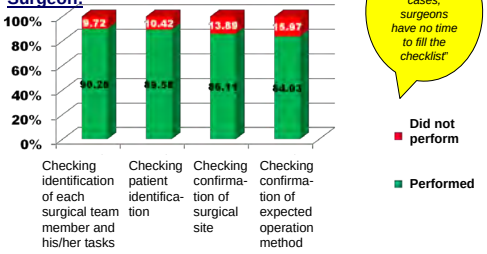
Evaluate the surgical safety level in your department:

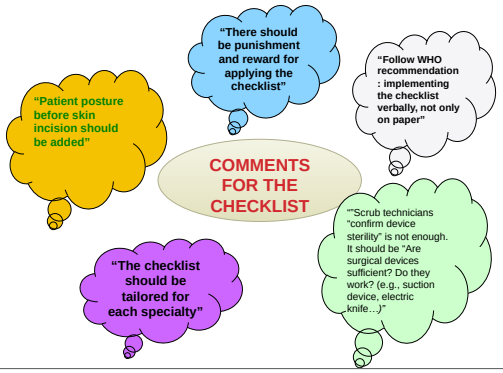


EVALUATION OF PRACTICE

Time out

Surgeon:

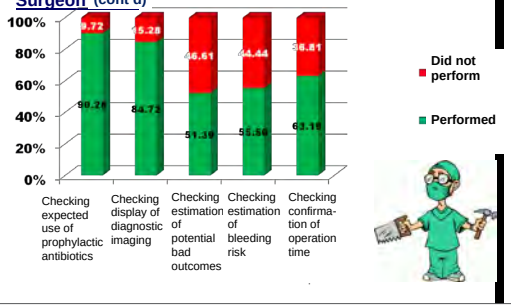




EVALUATION OF PRACTICE

Time out

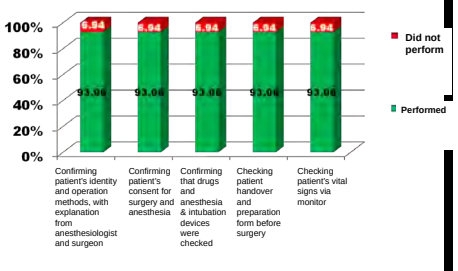
Surgeon (cont'd)



EVALUATION OF PRACTICE

Sign in

Anesthesia technicians:

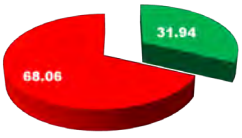


EVALUATION OF PRACTICE

Time out

Anesthesiologist:

Assessing and noting special issues related to patients

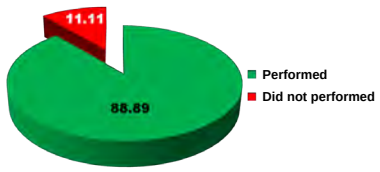


EVALUATION OF PRACTICE

Time out

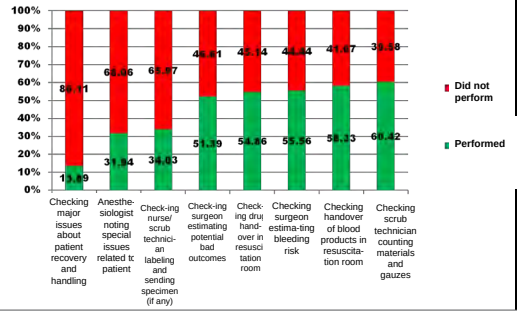
Nurse/Scrub technician:

Checking the confirmation of sterilization of devices and tools



EVALUATION OF PRACTICE

Activities healthcare workers often didn't mark in the checklist

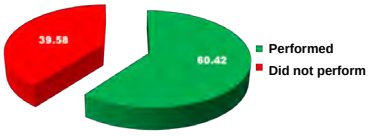


EVALUATION OF PRACTICE

Sign out

Nurse/Scrub technician:

Checking the completion of counting materials and gauzes



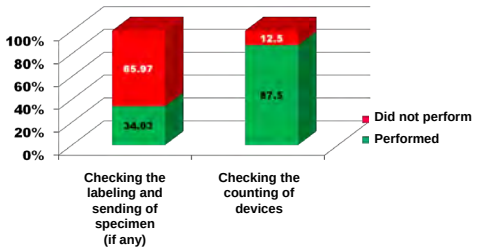
CONCLUSIONS

- A certain number of healthcare workers do not understand the helpfulness of the checklist and how to fill it
- The compliance rates with checklist use are still low in some items
- Most (92.71%) of healthcare workers want to be trained how to use the checklist.
- Some information in the checklist should be adjusted to be more appropriate

EVALUATION OF PRACTICE

Sign out

Nurse/Scrub technician:



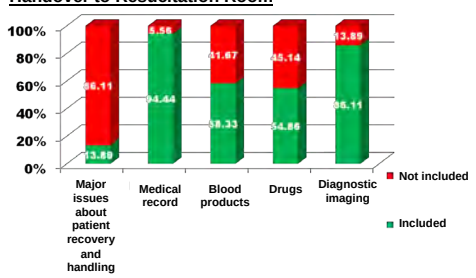
SOLUTIONS

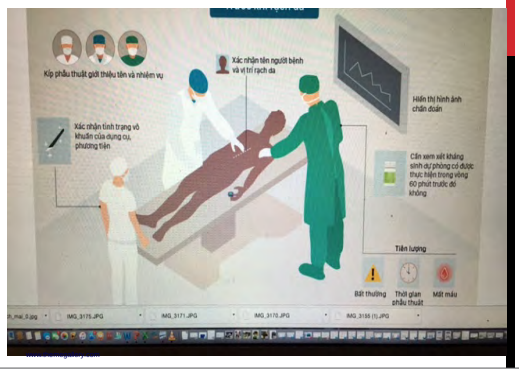
- Revise part of the checklist
- Organize trainings on how to use the checklist for healthcare workers who involve in surgeries, especially for the groups and items in the checklist whose/of which compliance rates are low
- Design visualized reminding boards to increase the compliance of healthcare workers

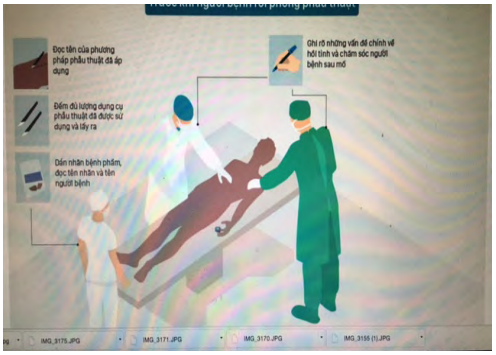
EVALUATION OF PRACTICE

Sign out

Handover to Resucitation Room




Kíp phẫu thuật giới thiệu tên và nhiệm vụ
Xác nhận tình trạng vô khuẩn của dụng cụ, phương tiện
Xác nhận tên người bệnh và vị trí rạch da
Hiển thị hình ảnh chẩn đoán
Tiên lượng
Bất thường
Thời gian phẫu thuật
Mất máu


Đọc tên của phương pháp phẫu thuật đã áp dụng
Đếm đủ lượng dụng cụ phẫu thuật đã được sử dụng và lấy ra
Dán nhãn bệnh phẩm, đọc tên nhân và tên người bệnh
Ghi rõ những vấn đề chính về hồi tỉnh và chăm sóc người bệnh sau mổ
www.themegallery.com


THANK YOU!
PATIENT SAFETY

Session 4-2

Some Experience in Applying Surgical Safety Checklist in Ha Tinh Provincial General Hospital

Hoang Song Hao

Quality Management Department, Ha Tinh Provincial General Hospital

1. Overview

Surgery is a medical technique applied for diagnosis, treatment, orthopedics…, which is common in health care. However, errors or incidents may occur any time during the operation process. Adverse events may occur before, during or after the operation, or even years after the patient discharges hospital, affecting both physical and mental health for a long time. Consequences not only affect surgical quality but also prolong treatment and hospitalization, decrease patients' income, increase treatment cost, morbidity and mortality rates, patients' pains, denunciations and legal problems.

According to a report by World Health Organization (WHO), there are about 230 million surgeries performed in the world annually. Life-threatening complications account for 16% (7 million cases), 10% of which causing patients' deaths (1 million cases) were related to surgeries in grand operation theaters.

In Viet Nam and the world in recent years, many surgical errors adversely affected patients' health. For example, organ transplantations were conducted from an HIV infected patient to 5 people in Taiwan in 2011, a 21-month boy was wrongly cystectomized in Cam Ranh City Hospital (Khanh Hoa Province), and wrong nephrectomy in Can Tho Central Hospital...

2. Implementation of safety surgery checklist in Ha Tinh Provincial General Hospital

Ha Tinh Provincial General Hospital is a 1st level provincial hospital with 38 departments/units, including: 08 functional departments, 23 clinical departments, 06 para-clinical departments, and 01 committee. The total number of staff is 723. There are 500 planned beds and 1,200 actual beds. There are 800-1,200 inpatients and 12,000–14,000 surgeries per year. With the motto "Safe, friendly, hospital for people", safety in treatment has always been our top priority. In the past years, there have been many ways to help make surgeries safe for patients. However, there are no tools that address the surgical process comprehensively. Therefore, in 2015, the Directing Board decided to apply the WHO surgical safety checklist (SSC) in the hospital. However, like other hospitals in the country, before introducing the checklist, we modified and improved it so that it suits our hospital. We apply it consistently and effectively in surgical departments, three specialized departments, and Surgery – Anesthesia Department.

1. Difficulties at the beginning

- Most surgeons, anesthesiologists, technicians... felt that this created more work and burden, some people didn't take it seriously;

- The application at the begining was limited because the checklist was not compatible with actual clinical settings, such as no administrative part, no signature part, which made it difficult to identify who is responsible if errors occur;

- The procedure was not clear, causing more difficulties for implmentation;

- There was no specific division of tasks, so there were some perfunctory implementers, some checklists were even completed after surgeries...

2. Improvement and application

After some time of checklist use, it showed some limitations, therefore improvement was necessary. The hospital decided to improve it comprehensively:

- The QM Council assigned the QMD to develop a

new draft checklist and implementation procedure by studying the WHO checklist and those used in other hospitals as well as collecting comments from surgeons, anesthesiologists, technicians...

- After that, the draft was sent to surgical departments, 3 specialized departments, and Anesthesia & Surgery Department to collect comments.

- QMD collected and summarized comments.

- QM Council and leaders of relevant departments had meetings to discuss and reach consensus on how to improve the checklist and implementation procedure as well as on which departments are responsible for implementing, checking and monitoring...

- QMD summarized comments and finalized the checklist before the director approved and issued it. The number of items in the checklist increased from 16 to 23.

- Surgery - Anesthesia Department and surgeons were trained on surgical safety, the necessity of using the surgical checklist recommended by WHO, and the revised implementation procedure.

- The checklist has been implemented in Surgery

- Anesthesia Department and three specialized departments: Opthalmology, ENT, and Odonto-Stomatology.

- Compliance of the checklist is checked monthly and unannounced.

- Types of check:

  - Regular check: daily check of medical records of surgical patients in the meeting hall, check medical records in GPD;
  - Unannounced check: direct check in Surgery

- Anesthesia Department by comparing the checklist and the on-going surgical process (instantaneous).

3. Good points in implementation after improvement

- Surgeons, anethesiologists, nurses, scrub nurses understand the necessity and importance of checklist implementation in surgery and procedure.

- High consensus among surgeons, anesthesiologists, nurses, and scrub technicians because they had opportunities to give comments for improvement and were trained carefully.

- Surgery - Anesthesia Department was assigned as the leader, in which the anesthesiologist takes main responsibility, which facilitates implementation.

4. Results

At present, Patient & Staff Safety Committee's checking and monitoring results show that the checklist is implemented strictly and properly. However, inspections also reveal some issues to be improved, such as: some columes were left blank, lack of signature, lack of diagnosis information...

5. Lessons learnt

To implement the checklist and maintain the practice, we need:

- The Directing Board's support and intensive direction.

- To organize trainings several times, emphasizing the necessity of checklist use in surgeries so that surgeons, anethesiologists, anesthesia technicians... understand that this practice is their responsibility and also benefit.

- Encouragement and supportive environment for people to give comments during implementation and revision. Respect everyone's opinions. Listen and revise if comments are suitable, with the motto "Always listening, always understanding".

- The SSC is only one step in ensuring safety for patients in a long treatment process, from reception, pre-operative preparation, operation, to post-operative care.

- Surgeons, the leader of the whole surgery, from anesthesia through the end of the surgery, benefit the most in checklist use. Therefore, while Surgery - Anesthesia Department is responsible for implementation, surgeons must be the last to check and sign the checklist, after the completion of gauze count, device check, drain insertion, and prognosis after the surgery.

- Strengthen checking, monitoring, and daily reminding. Dicipline must be applied to individuals or surgical teams that do not implement well, such as: blame or reduced bonus. Checking and monitoring are really important to maintain checklist use in surgery.

6. Current difficulties

After some time of checklist use, some surgeons, especially excellent ones and those with strong personality, seem to be less serious and skip some items in the checklist.

3. Conclusions

Using SSC in hospitals is really necessary. To maintain this work, it requires intensive direction from the Directing Board and checking and monitoring to be conducted both regularly and unannounced. To keep this practice effective in the long term, Surgery - Anesthesia Department plays

a really important role, together with consensus among surgeons, anesthesiologists, anesthesia technicians on serious implementation of this checklist.

I. Overview

- According to a WHO report, there are about 230 million surgeries performed in the world annually.
- Life-threatening complications account for 16% (7 million cases), 10% of which caused patients' deaths (1 million cases).

HA TINH DEPARTMENT OF HEALTH
HA TINH PROVINCIAL GENERAL HOSPITAL

Some experience in
implementing Surgical Safety Checklist in Ha Tinh Provincial General Hospital

Dr. Hoang Song Hao
Chief of Quality Management Department
Ha Tinh Provincial General Hospital

I. Overview

- In Viet Nam and the world in recent years, many surgical errors adversely affect patients' health and prestige of hospitals and the health sector.
- Organ transplantations were conducted from an HIV infected patient to 5 people in Taiwan in 2011, a 21-month boy was wrongly cystectomized, or wrong nephrectomy...

I. Overview

- Surgery is a medical technique applied for diagnosis, treatment, orthopedics..., which is common in health care.
- However, errors or incidents may occur any time during the operation process.
- Its consequences affect the surgery's quality, increase patients' costs, length of stay, morbidity, mortality, denunciations and legal problems.

Implementation of SSC in Ha Tinh Provincial General Hospital

- Ha Tinh Provincial General Hospital is a 1st level provincial hospital with 38 departments/units, including: 08 functional departments, 23 clinical departments, 06 para-clinical departments, and 01 Committee.
- 723 employees. 500 planned beds and 1,263 actual beds.
- 800-1,200 inpatients and 12,000–14,000 surgeries per year.

Implementation of SSC in Ha Tinh Provincial General Hospital

- With the motto "Safe, friendly, hospital for people", safety in treatment has always been our top priority.
- In the past years, there have been many ways to help make surgeries safe for patients. However, there are no tools that address the surgical process comprehensively.
- Therefore, in 2015, the Directing Board decided to apply the WHO SSC in the hospital.

Improvement and application

- QM Council and leaders of relevant departments had meetings to discuss, reach consensus, and divide tasks...
- QMD summarized comments and finalized the checklist before the Director approved and issued it.
- Surgery - Anesthesia Department and surgeons were trained on surgical safety, the necessity of using the surgical checklist recommended by WHO, and the revised implementation procedure.
- The checklist has been applied in the whole hospital.

Difficulties at the beginning

- Most surgeons, anesthesiologist, technicians... felt that this created more work and burden, some people didn't take it seriously.
- The application at the begining was limited due to lack of experience and the checklist contents were still poor;
- The procedure was not clear, causing more difficulties;
- There was no specific division of tasks, so there were some perfunctory implementors, some checklists were even completed after surgeries...

How to maintain?

- Strengthen checking
- Regular and unannounced check

  - Regular check: daily check of medical records of surgical patients in the meeting hall, check medical records in GPD

  - Unannounced check: direct check in Surgery - Anesthesia Department by comparing the checklist and the on-going surgical process (instantaneous).

Improvement and application

- After some time of checklist use, it showed some limitations, therefore improvement was necessary. The hospital decided to improve it.
- The QM Council assigned the QMD to develop a new draft checklist and implementation procedure.
- After that, the draft was sent to surgical departments, 3 specialized departments, and Surgery - Anesthesia Department to collect comments => showing democracy and respect to implementers.
- QMD collected and summarized comments.

Checking, monitoring and direct discussion to learn from experiences

Steps before applying the revised version

Good points in implementation after improvement

- Surgeons, anesthesiologists, nurses, scrub technicans understand the necessity and importance of checklist use.
- High consensus among surgeons, anesthesiologists, nurses, and scrub technicians because they had opportunities to give comments for improvement and were trained carefully.
- Surgery - Anesthesia Department was assigned as the leader, in which the anesthesiologist takes main responsibility, which facilitates implementation.
- QM Council assigned me to monitor implementation => an advantage

Results

- At present, Patient & Staff Safety Committee's checking and monitoring shows that the checklist is implemented strictly and properly.
- However, inspections also reveal some issues to be improved, such as: some columes were left blank, lack of signature, lack of diagnosis information...
- Sometimes, some departments had to be asked to pay more attention.

Current difficulties

- After some time of checklist use, some surgeons, especially excellent ones and those with strong personality, seem to be less serious and skip some items in the checklist.

Lessons learnt

To implement the checklist and maintain the practice, it needs:

- The Directing Board's support and intensive direction
- Trainings to be organized several times, emphasizing the necessity of checklist use in surgeries
- Encouragement and supportive environment for people to give comments during implementation and revision.
- Respect to everyone's opinions. Listen and revise if comments are suitable, with the motto "Always listening, always understanding".

Conclusions

- Using SSC in hospitals is really necessary.
- To maintain this work, it requires intensive direction from the Directing Board and good collaboration among relevant departments.
- Checking and monitoring must be conducted both regularly and unannounced.

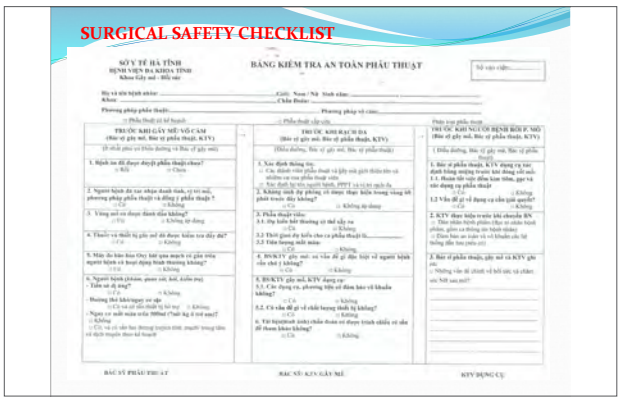
- The SSC is only one step in ensuring safety for patients during their stay in the hospital.
- Surgeons, the leader of the whole surgery, from anesthesia through the end of the surgery, benefit the most in checklist use.
- Therefore, while Surgery - Anesthesia Department is responsible for implementation, surgeons must be the last to check and sign the checklist, after the completion of gauze count, device check, drain insertion, and prognosis after the surgery.

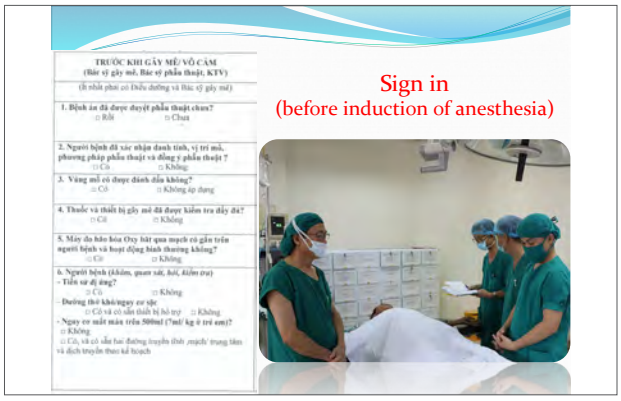
Conclusions

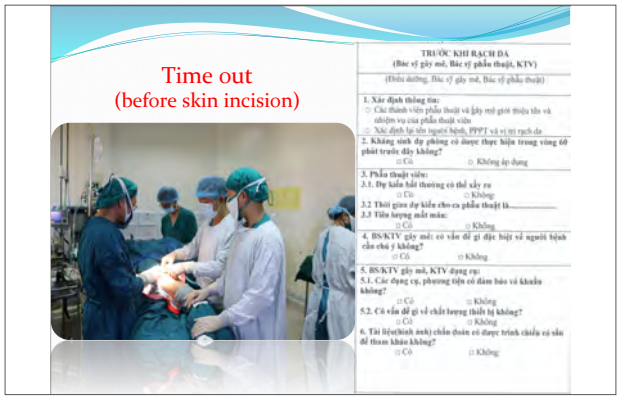
- Timely direction from QM Council. Comments from Surgery - Anesthesia Department, surgeons, technicians, etc. should be listened.
- To keep this practice effective in the long term, Surgery - Anesthesia Department plays a really important role, together with consensus among surgeons, anesthesiologists, anesthesia technicians on serious implementation of this checklist.

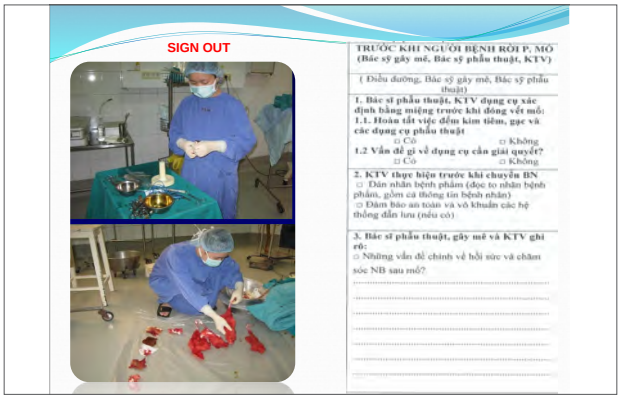
- Strengthen checking, monitoring, and daily reminding. Dicipline must be applied to individuals or surgical teams that do not implement well, such as: blame or reduced bonus
- Checking and monitoring are really important to maintain checklist use in surgery.

Thank you for your attention!


SURGICAL SAFETY CHECKLIST
BẢNG KIỂM TRA AN TOÀN PHẪU THUẬT


Sign in
(before induction of anesthesia)


Time out
(before skin incision)


SIGN OUT

Session 4-3

Actual State of Applying Surgical Safety Checklist in Hue Central Hospital

Phan Hai Thanh, Nguyen Thanh Xuan, Tran Le Bao Tram, Dang Duy Quang, Pham Nguyen Da Thao, Tran Thi Thuy Phuong, Tran Huu Nhat Duy, Le Ho Xuan Thinh

Quality Management Department, Hue Central Hospital

1. Introduction

Surgical adverse events are incidents that unexpectedly harm patients. Incidents of any levels and with any causes can seriously affect the patient's physical and mental health. Annually, there are about 234 million surgeries in the world, 0.4-0.8% of which cause mortality, 3-16% have complications, and 7 million with permanent injuries. A study on medical incidents in Canada (2004) and others in the world show that more than 50% of the incidents relate to surgery and related complaints are very costly. In Viet Nam, big hospitals are always overcrowded and suffer high work pressure, especially in surgery and anesthesia departments. Many adverse events happen due to mistakes during preparation and control before, during and after surgery. These events can be controlled or minimized if there is a strict controlling process. Hue Central Hospital has applied an SSC since September 2011. There were many difficulties at the beginning. However, after 5 years of implementation, healthcare workers are more and more self-disciplined and responsible in complying to implementing the checklist.

In Viet Nam, there is no study which evaluates the application of SSC. The study evaluates the actual state of applying SSC in Hue Central Hospital.

2. Subjects and methodology

2.1. Subjects

- 841 patients who underwent surgeries in Anesthesia Department A, Hue Central Hospital, from June 1 to July 1, 2016

- Patients with emergency or planned surgeries (gastroenterology, orthopedics, neurosurgery, urology)

- Excluding people with comma, deaf, mute, or communication difficulties.

2.2. Methodology

- A prospective, descriptive, cross-sectional study

2.3. Tool

- An SSC (revised from WHO SSC 2009 to suit Hue Central Hospital)

- Medical records

2.4. Evaluation steps

- "Before induction of anesthesia" (7 questions)

- "Before skin incision" (10 questions)

- "Before patient leaves operating room" (5 questions)

2.5. Evaluation indicators

- Emergency and planned surgeries

- Rates of filling the checklist at each point of time

- Rates of filling each question at different points of time

- Rates of completing the checklist

- Compliance rates of surgeons, anesthesiologists, nurses

- Analyze reasons why checklists were not completed

3. Results

- Emergency surgeries/planned surgeries: 244/597

- Rates of filling the checklist at each point of time

  - Before induction of anesthesia: emergency surgery 72.52%, planned surgery 84.14%
  - Before skin incision: emergency surgery 70.03%, planned surgery 76.1%

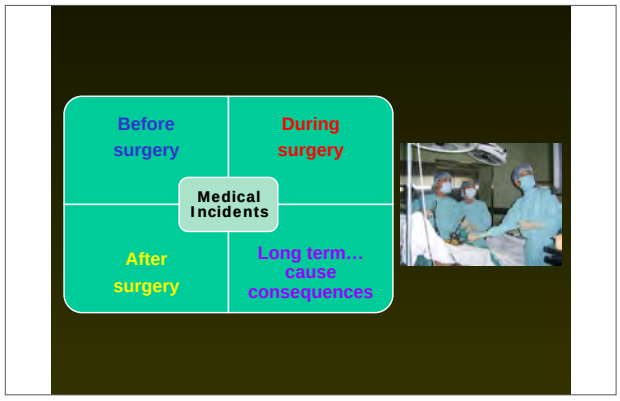
- Before patient leaves operating room: emergency surgery 83.35%, planned surgery 87.14%

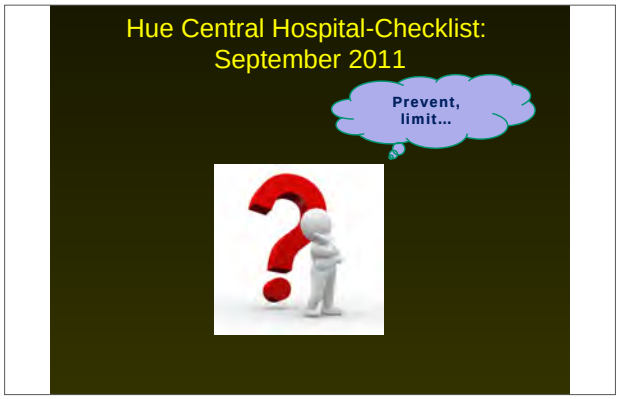
- Rates of completing the checklist
  - Emergency surgery: 69.85%
  - Planned surgery: 75.46%

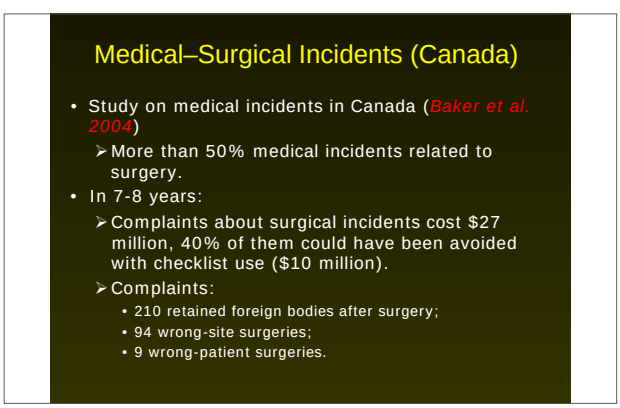
- Compliance rates of surgeons, anesthesiologists, nurses
  - Surgeons: 72.12%
  - Anesthesiologists: 78.56%
  - Nurses: 91.8%

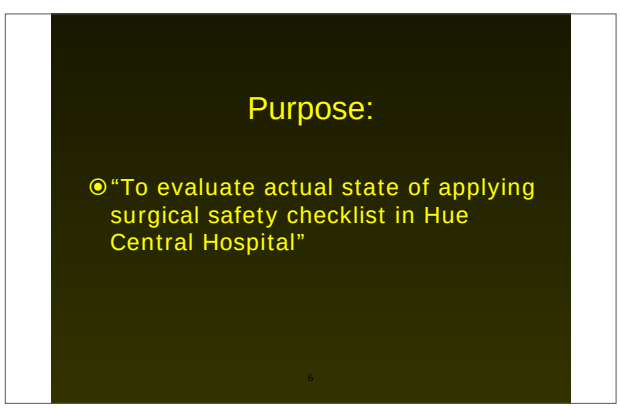
4. Conclusion

The research results show that the compliance rates of healthcare workers are not high. It is concerned that surgical errors may occur in the future and it requires higher awareness of healthcare workers in implementing SSC as well as effective ways to monitor this activity.









RESEARCH SUBJECTS AND METHODOLOGY

Subjects:

✓Surgical patients in Anesthesia Department A
✓June 1–30, 2016
✓Emergency or planned surgeries (Gastroenterology, Orthopedics, Neurology, Urology)

Exclusion:

- Patients with coma, deaf or mute
- Patients with communication difficulties…

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Checklist - Content 2
Before skin incision

Time out

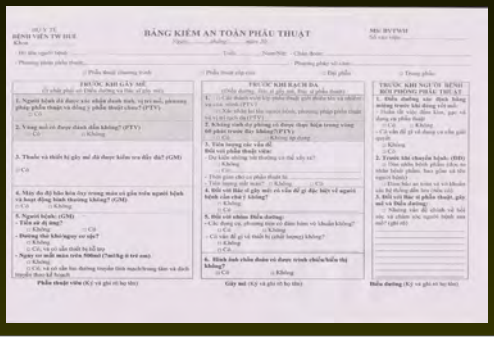
Before operation starts

- Nurse, anesthesiologist, surgeon

- Members of surgical team introduce name and tasks
- Prophylactic antibiotics
- Surgeons/prognosis
- Anesthesia/prognosis?
- Nurse/tools, devices, drugs, asepsis…

BỆNH VIỆN TRUNG ƯƠNG HUẾ
HUE CENTRAL HOSPITAL

Tool


BẢNG KIỂM AN TOÀN PHẪU THUẬT

Checklist - Content 3
Before patient leaves operating room

Sign out

What to complete before patient leaves operating room:

- Counting: needles, gauzes, tools
- Tool problems?
- Labeling specimen (if any)
- Drains
- Checking resuscitation safety
- Nursing care

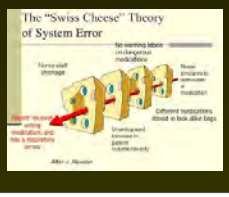
Nurse, anesthesiologist, surgeon

3 checks

- Before induction of anesthesia (Sign in): 7 Questions
- Before skin incision (Time out): 10 questions
- Before patient leaves operating room (Sign out): 5 questions

Research

- Emergency and planned surgeries
- Rates of filling the checklist at each point of time
- Rates of filling each question at different points of time
- Rates of completing the checklist
- Compliance rates of surgeons, anesthesiologists, nurses
- Analyze reasons why checklists were not completed.



Checklist - Content 1
Before induction of anesthesia

Sign in

After patient enters operating room and before induction of anesthesia

- There must be at least a nurse and an anesthesiologist

- Confirmation of patient identity, surgical site, and surgical method
- Mark the surgical site
- Drug and anesthesia devices
- Pulse oximeter
- Allergy, airway

Results

SSC application (01/6/2016 to 30/6/2016)

Classification	N	Percentage %
a. Emergency surgeries	244	29.02
b. Planned surgeries	597	70.98
Total:	841	100

Completion rates "Before induction of anesthesia"

Contents	Emergency (n = 244)				Planned (n = 597)			
	Checked		Not checked		Checked		Not checked	
	N	%	N	%	N	%	N	%
1. Has patient confirmed his/her identity, surgical site, surgical method and agreed to surgery?	190	77.86	54	22.14	522	87.43	75	12.57
2. Is surgical site marked?	183	75	61	25	505	84.58	92	15.42
3. Drugs and anesthesia devices have been checked fully	201	82.37	43	17.63	546	91.45	51	8.55

Completion rates "Before skin incision"

Contents	Emergency (n = 244)				Planned (n = 597)			
	Checked		Not checked		Checked		Not checked	
	N	%	N	%	N	%	N	%
4. Assessing potential abnormalities?	193	79.09	51	20.91	473	79.22	124	20.78
5. Length of operation	187	76.63	57	23.37	461	77.21	136	22.79
6. Anticipation of blood loss	178	72.95	66	27.05	490	82.07	107	17.93
7. Patient's issues that need special attention	171	70.08	73	29.92	460	77.05	137	22.95

Completion rates "Before induction of anesthesia"

Contents	Emergency (n = 244)				Planned (n = 597)			
	Checked		Not checked		Checked		Not checked	
	N	%	N	%	N	%	N	%
4. Is pulse oximeter attached to patient and does it work?	191	78.27	53	21.73	532	89.11	65	10.89
5. Patient has allergy history	195	79.91	49	20.09	553	92.62	44	7.38

Completion rates "Before skin incision"

Contents	Emergency (n = 244)				Planned (n = 597)			
	Checked		Not checked		Checked		Not checked	
	N	%	N	%	N	%	N	%
8. Are devices and tools aseptic?	223	91.30	21	8.70	549	91.95	48	8.05
9. Are there any problems with equipment (quality)?	210	86.06	34	13.93	520	87.10	77	12.90
10. Are diagnostic imaging results displayed?	188	76.04	56	22.96	479	80.23	118	19.77

Completion rates "Before induction of anesthesia"

Contents	Emergency (n = 244)				Planned (n = 597)			
	Checked		Not checked		Checked		Not checked	
	N	%	N	%	N	%	N	%
6. Patient has breathing difficulty and risk of choking	189	77.46	55	22.54	545	91.28	52	8.72
7. Risk of losing 500ml or more of blood (7ml/kg in children)	184	75.41	60	25.59	522	87.43	75	12.57

Completion rates "Before patient leaves operation theater"

Contents	Emergency (n = 244)				Planned (n = 597)			
	Checked		Not checked		Checked		Not checked	
	N	%	N	%	N	%	N	%
1. Completion of counting gauzes and surgical tools	234	95.90	10	4.10	576	96.48	21	3.52
2. Are there any instrument problems that need to be solved	207	84.83	37	15.17	531	88.94	66	11.06
3. Labeling specimen (read aloud labels, including patient's name)	231	94.67	13	5.33	572	95.81	25	14.19

Completion rates "Before skin incision"

Contents	Emergency (n = 244)				Planned (n = 597)			
	Checked		Not checked		Checked		Not checked	
	N	%	N	%	N	%	N	%
1. Members of surgical team introduced their name and tasks	171	70.08	73	29.92	464	77.72	133	22.28
2. Reconfirm patient's name, surgical site and method	176	72.13	68	27.87	458	76.71	139	23.29
3. Has prophylactic antibiotics been given in the last 60 minutes?	177	72.54	67	27.46	454	76.04	143	23.96

Completion rates "Before patient leaves operation theater"

Contents	Emergency (n = 244)				Planned (n = 597)			
	Checked		Not checked		Checked		Not checked	
	N	%	N	%	N	%	N	%
4. Ensure that drains are safe and aseptic (if any).	205	84.01	39	15.99	537	89.94	60	10.06
5. Major issues about resuscitation and postoperative care	212	87.60	32	12.40	535	89.61	62	10.39

Results

Rates of full completion of the surgical safety checklist

Classification	N	Percentage %
a. Emergency surgeries	170/244	69.85
b. Planned surgeries	450/597	75.46

Surgical safety will avoid:

- Mortality, surgical errors
- Surgical site infection
- Poor communication among teams
- Threatening legal problems

Results

Compliance rates of surgeons, anesthesiologists, nurses

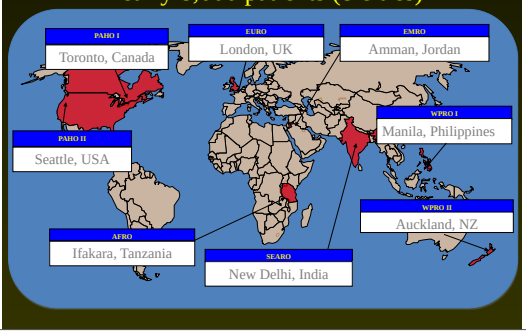
Classification	N	Percentage %
a. Surgeons	607	72.12
b. Anesthesiologists	661	78.56
c. Nurses	772	91.8

WHO SSC

Checklist in the health sector?

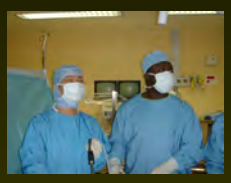
- **In 2001**, a doctor in John Hopkins Hospital tried a checklist to prevent infection during minor surgeries
- A 5-step checklist was introduced and nurses were requested to observe the doctor's performance according to the checklist
- **In 2004**, about 230 million of major surgeries were conducted in the world; as a result, 7 million people suffered from injuries and more than 1 million people died.
- **In 2006**, WHO started a global program to reduce injuries and mortality
- A "Surgical Safety Checklist" was developed, including 3 stages:
  - Before induction of anesthesia
  - Before skin incision
  - Before patient leaves operation theater

An international pilot study
Nearly 8,000 patients (8 cities)



Operation Theater Checklist?

- Ensuring safe and effective working teams
- Successful operations



...utilization of surgical safety checklist reduces more than 1/3 of postoperative complications and deaths!

Haynes et al. A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. New England Journal of Medicine 360:491-9. (2009)

Results:

	Baseline	Checklist	P value
Cases	3,733	3,955	-
Death	1.5%	0.8%	0.003
Any Complication	11.0%	7.0%	<0.001
SSI	6.2%	3.4%	<0.001
Unplanned Reoperation	2.4%	1.8%	0.047

Haynes et al. A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. New England Journal of Medicine 360:491-9. (2009)

Checklist benefits? (cont'd)

- Safety for anesthesia and resuscitation
  - An analysis of 1,256 incidents related to general anesthesia in Australia shows that about 82% of the incidents related to SPO2 measure (pulse oximeter).[1]

[1] *Webb, Anaesthesia and Intensive Care, 1993.*

Changes in complication and mortality rates by income

	Change in complication rate	Change in mortality rate
High income	10.3% -> 7.1%*	0.9% -> 0.6%
Low and average income	11.7% -> 6.8%*	2.1% -> 1.0%*

* $p<0.05$

Haynes et al. A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. New England Journal of Medicine 360:491-9. (2009)

Checklist benefits? (cont'd)

- Reduction of infection risks:
  - Use antibiotics 1 hour before skin incision reduced 50% of infection risks [1, 2]

[1] *Bratzler, The American Journal of Surgery, 2005.*
[2] *Classen, New England Journal of Medicine, 1992.*

Survey on physicians' attitude towards checklist implementation (n = 229)

Easy to use	78.6%
Safety in operation theater improved	79.0%
Time consuming to complete	18.3%
Communication improved	84.3%
Contribution to prevent incidents in operation theater	78.2%
Expect to use checklist	**92.6%**

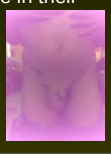
Checklist benefits? (cont'd)

- Effective teamwork[1,2,3]

[1] *Joint Commission, Sentinel Event Statistics, 2006.*
[2] *Makary, Joint Commission Journal on Quality and Patient Safety, 2006.*
[3] *Altpeter, Journal of the American College of Surgeons, 2007.*

Checklist benefits?

- Correct patient, correct surgery and correct surgical site
  - 1,500-2,500 wrong-site surgeries a year in the US.[1]
  - A survey of 1,050 surgeons: 21% performed wrong-site surgery at least once in their career[2]



[1] *Seiden, Archives of Surgery, 2006.*
[2] *Joint Commission, Sentinel Event Statistics, 2006.*

Checklist benefits? (cont'd)

- Effective teamwork[1,2,3]

[1] *Joint Commission, Sentinel Event Statistics, 2006.*
[2] *Makary, Joint Commission Journal on Quality and Patient Safety, 2006.*
[3] *Altpeter, Journal of the American College of Surgeons, 2007.*

Checklist benefits? (cont'd)

- Effective teamwork[1,2,3]

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[2] *Makary, Joint Commission Journal on Quality and Patient Safety, 2006.*
[3] *Altpeter, Journal of the American College of Surgeons, 2007.*

MANAGED UPTAKE OF MEDICAL METHODS REVIEW

ORIGINAL ARTICLE

Evaluation of a Preoperative Checklist and Team Briefing Among Surgeons, Nurses, and Anesthesiologists to Reduce Failures in Communication

Lorelei Lingard, PhD; Glenn Regehr, PhD; Beverley Orser, MD, PhD; Richard Reznick, MD, MEd; G. Ross Baker, PhD; Diane Doran, RN, PhD; Sherry Espin, RN, PhD; John Bohnen, MD; Sarah Whyte, MA

Objective: To assess whether structured team briefings improve operating room communication.

Design, Setting, and Participants: This 13-month prospective study used a preintervention/postintervention design. All staff and trainees in the division of general surgery at a Canadian academic tertiary care hospital were invited to participate. Participants included 11 general surgeons, 24 surgical trainees, 41 operating room nurses, 28 anesthesiologists, and 24 anesthesia trainees.

Intervention: Surgeons, nurses, and anesthesiologists gathered before 302 patient procedures for a short team briefing organized by checklist.

comes were the number of checklist briefings that demonstrated "utility" (an effect on the knowledge or actions of the team) and participants' perceptions of the briefing experience.

Results: One hundred seventy-two procedures were observed (86 preintervention, 86 postintervention). The mean (SD) number of communication failures per procedure declined from 3.95 (3.20) before the intervention to 1.31 (1.53) after the intervention ($P<.001$). Thirty-four percent of briefings demonstrated utility, including identification of problems, resolution of critical knowledge gaps, decision-making, and follow-up actions.

Evidence

MANAGED UPTAKE OF MEDICAL METHODS REVIEW

A surgical checklist increases patient safety

Background
In 2007, WHO launched a worldwide Safe Surgery Saves Lives campaign to decrease the risk of surgical complications. An international group of experts developed a surgical checklist that was piloted in eight different centers around the world. The aim of the present MUMM (Managed Uptake of Medical Methods) review was to evaluate the effectiveness of checklists in the prevention of surgical complications.

Methods
A systematic literature review of electronic databases (Medline, HTA) was conducted. The GRADE system was used for the evaluation of quality and evidence. In addition, vital statistics about surgery in Finland were assessed.

Results
Use of the WHO checklist had been examined in one multinational prospective comparative study. The checklist was found to reduce the rate of postoperative complications by more than one third. In countries with a high gross national product (GNP), the rate of surgical complications decreased from 10.3% to 7.4% and mortality from 0.8% to 0.4%. Converted to NNT (number-needed-to-treat), if the list were used 31 times, one complication would be prevented, and if it were used 333 times, one death would be prevented. No checklist-related adverse events have been reported.

Conclusions
The surgical checklist is a simple method, and there is evidence for its effectiveness in reducing complications in clinical use. WHO recommends use of the checklist in all surgical operations and encourages clinicians to modify the list for different specialties and hospitals.

EVALUATION OF CHECKLIST IMPLEMENTATION

- The Directing Board of Hue Central Hospital requested the application of an SSC in all anesthesia-resuscitation departments, targeting all surgical patients and attaching the checklist to medical records to minimize surgical errors.
- Checklist implementation has not been paid enough attention: the rates of checked items were not high. From 1st-30th June 2016, there were 841 surgeries in Anesthesia-Resuscitation Department A but only 69.85% of emergency surgeries and 75.46% of planned surgeries completed checklists.

The Publication – January 15th 2009

THE NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population

Alex B. Haynes, M.D., M.P.H., Thomas G. Weiser, M.D., M.P.H., William R. Berry, M.D., M.P.H., Stuart R. Lipsitz, Sc.D., Abdel-Hadi S. Breizat, M.D., Ph.D., E. Patchen Dellinger, M.D., Teodoro Herbosa, M.D., Sudhir Joseph, M.S., Pascience L. Kibatala, M.D., Marie Carmela M. Lapitan, M.D., Alan F. Merry, M.B., Ch.B., F.A.N.Z.C.A., F.R.C.A., Krishna Moorthy, M.D., F.R.C.S., Richard K. Reznick, M.D., M.Ed., Bryce Taylor, M.D., and Atul A. Gawande, M.D., M.P.H., for the Safe Surgery Saves Lives Study Group*

EVALUATION OF CHECKLIST IMPLEMENTATION

- Checklist completion rates were higher in planned surgeries.
- Nurses checked more items than doctors.

Results

Table 5. Outcomes before and after Checklist Implementation, According to Site.*

Site No.	No. of Patients Enrolled		Surgical-Site Infection		Unplanned Return to the Operating Room		Pneumonia		Death		Any Complication	
	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After
							percent					
1	524	598	4.0	2.0	4.6	1.8	0.8	1.2	1.0	0.0	11.6	7.0
2	357	351	2.0	1.7	0.6	1.1	3.6	3.7	1.1	0.3	7.8	6.3
3	497	486	5.8	4.3	4.6	2.7	1.6	1.7	0.8	1.4	13.5	9.7
4	520	545	3.1	2.6	2.5	2.2	0.6	0.9	1.0	0.6	7.5	5.5
5	370	330	20.5	3.6	1.4	1.8	0.3	0.0	1.4	0.0	23.4	5.5
6	496	476	4.0	4.0	3.0	3.2	2.0	1.9	3.6	1.7	10.1	9.7
7	525	585	9.5	5.8	1.3	0.2	1.0	1.7	2.1	1.7	12.4	8.0
8	444	584	4.1	2.4	0.5	1.2	0.0	0.0	1.4	0.3	6.1	3.6
Total	3733	3955	6.2	3.4	2.4	1.8	1.1	1.3	1.5	0.8	11.0	7.0
P value			<0.001		0.047		0.46		0.003		<0.001	

* The most common complications occurring during the first 30 days of hospitalization after the operation are listed. Bold type indicates values that were significantly different (at $P<0.05$) before and after checklist implementation, on the basis of P values calculated by means of the chi-square test or Fisher's exact test. P values are shown for the comparison of the total value after checklist implementation as compared with the total value before implementation.

Session 4-4

Applying PDCA Cycle to Continuous Quality Improvement: an Example in the Antimicrobial Stewardship Program in Cho Ray Hospital

Ton Thanh Tra

Quality Management Department, Cho Ray Hospital

1. Introduction

PDCA stands for **Plan, Do, Check, Action**. PDCA cycle was introduced to the Japanese by doctor W. Edwards Deming in 1950's. At the beginning, he called it Shewart Cycle in memory of doctor Walter A. Shewart – a pioneer in checking quality by statistics in the United State in late 1930s. However, Japanese people usually call it Deming Cycle.

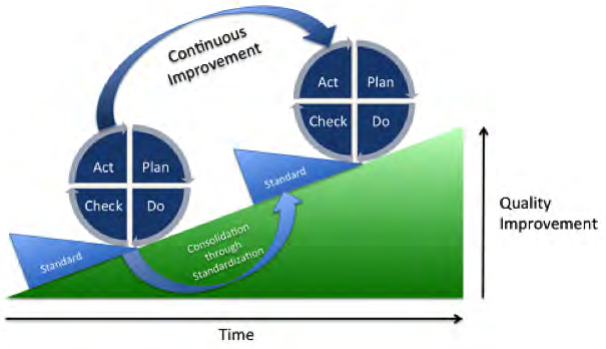
Contents of the cycle's stages are summarized as follows:

Plan: Make plan, setting objectives, scope, resources for implementation, time and methods to achieve objectives.

Do: Put the plan into operation.

Check: Check implementation results based on the plan.

Action: From obtained results, adjust to start another cycle and new input information.



http://hirayamavietnam.com.vn/wp-content/uploads/cai-tien-chat-luong-lien-tuc-voi-PDCA.png

PDCA cycle starts with planning. The improvement plan must be clear and detailed. Setting objective is a very important part, which requires that quality people have knowledge of the areas that need improvement and the objectives must be SMART, which is:

- Specific
- Measurable
- Achievable
- Realistic
- Timely

2. Application in the antimicrobial stewardship (AMS) program

AMS in the hospital is necessary, which helps minimize antibiotic overuse, which increases antibiotics resistance, length of hospital stay, and treatment costs. However, this is a quite big program that requires much time and effort. If we don't have a detailed plan and clear (short term and long term) objectives, it will be easy to fail. With many objectives set in this program, we apply the PDCA cycle to make it work effectively. After observing and studying initial results of the pilot program, we selected prioritized issues to tackle. I would like to share our objectives for AMS in surgery.

Reasons for selection:

- Every year, there are about 40,000 surgeries in Cho Ray Hospital, 50% of which were clean and uncontaminated thanks to using prophylactic antibiotics only.
- Surgeons have a habit of indicating antibiotics many days before and after the surgery.
- Scientific evidence and guidelines show that using antibiotics for many days after surgery is not beneficial.

We started applying PDCA cycles for continuous improvement to minimize improper antibiotics uses:

Plan: The program is one year, aiming at minimizing improper antibiotics uses in surgery.

Objectives for:

The first 6 months

- All planned surgeries' risks of surgical site infection (SSI) are classified

- Prophylactic antibiotics are indicated before surgeries

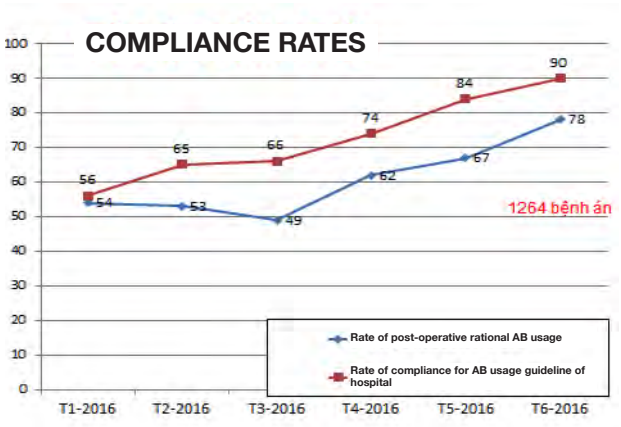
The next 6 months

- Compliance rates to guidance of prophylactic antibiotics use in surgery increase by 10% each month.

- Compliance rates to appropriate antibiotic use after surgery increase by 10% each month.

Do: The AMS committee meets every month. A clinical pharmacists group participate in randomly checking medical records in surgery departments. Regularly review antibiotics use in medical records. Provide guidelines on antibiotic use and practice tools (e.g., application on smartphone)

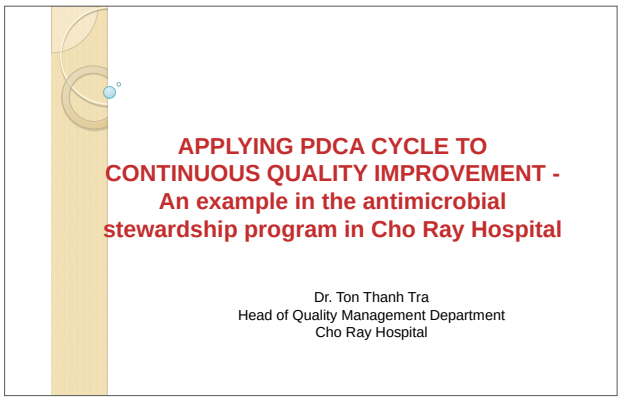
Check: To increase compliance rates, besides strengthened monitoring, the monitoring group conduct studies to provide scientific data to show safety and effectiveness of prophylactic antibiotic use.

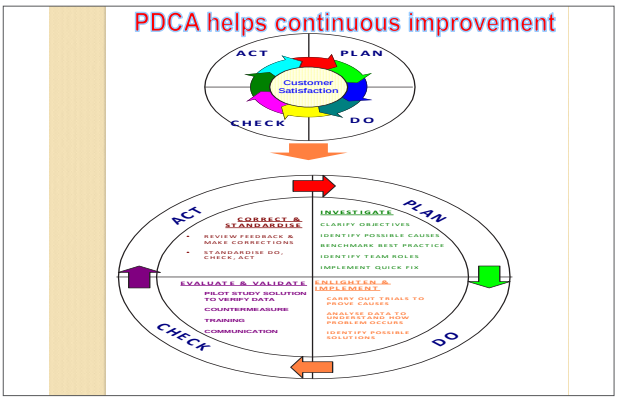


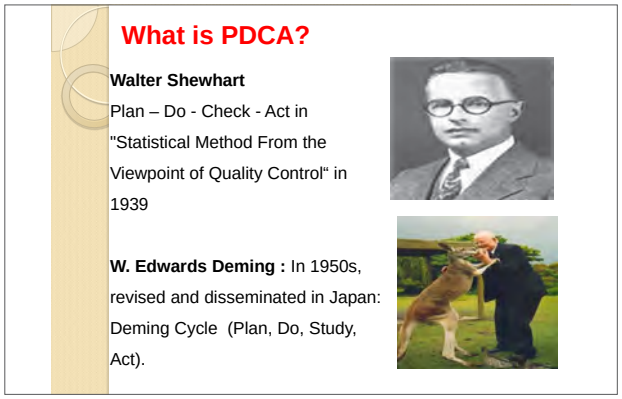
Results show that compliance rates increased remarkably over time. The number of days of antibiotics use and the quantity of antibiotics used decreased while the rates of SSI did not change.

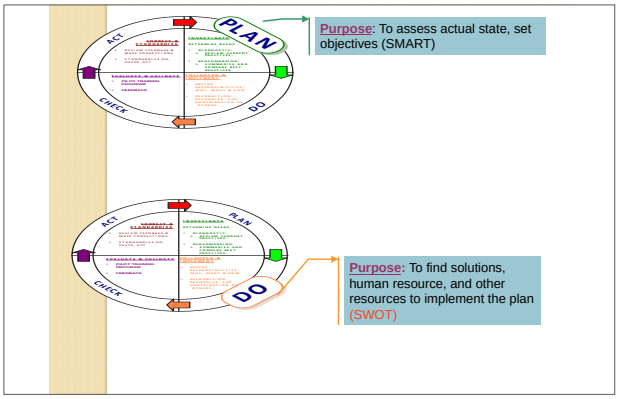
Act: Each monitoring round is a PDCA cycle with increased compliance rate objectives. Once we achieve one cycle's objectives, we set higher objectives and continue to improve.

Conclusions: PDCA cycle is an effective tool for continuous quality improvement (CQI) with the objective to enhance compliance rates of healthcare workers. Applying PDCA cycles bring short term and long term results and help CQI keep going.









Purpose: To monitor implementation, evaluate effectiveness. Measurement and monitoring methods.

Purpose: To implement widely, expand activities, develop new objectives.

HOW DO I APPLY PDCA CYCLE

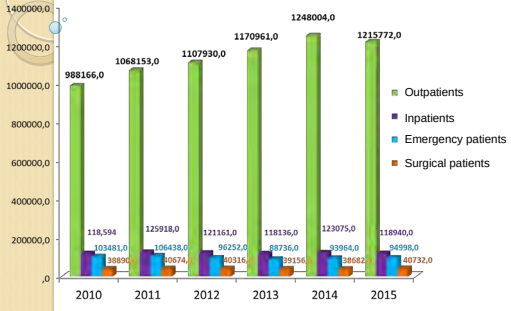
- Assessing actual state
- Setting objectives
- Implementation
- Measuring results
- Expansion
- Setting new objectives

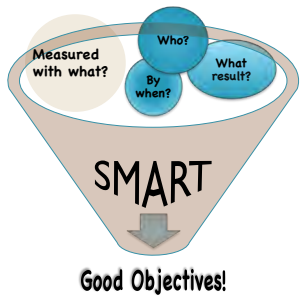
S.M.A.R.T. OBJECTIVES

- Specific
- Measurable
- Achievable
- Realistic
- Timely

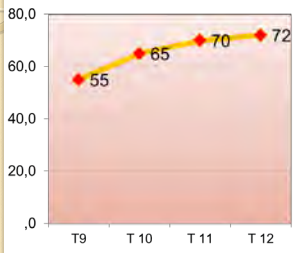
YOU ARE SMART BUT YOUR GOALS ARE NOT ALWAYS SMART

NUMBER OF PATIENTS FROM 2010 TO 2015





Proper indication of antibiotics after surgery



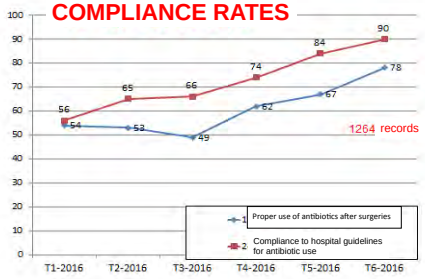
- Compliance to antibiotics indication in surgery increased but no evidence to indicate after surgery

YOU CAN NOT IMPROVE SOMETHING WITHOUT MEASURING IT !!!

APPLICATION OF PDCA CYCLE

Compliance rate increases by 5% in each PDCA cycle/month. Compliance rate reaches 80% after 6 months

COMPLIANCE RATES



DEVELOPMENT OF GUIDELINES, PROTOCOLS

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ECONOMIC EFFICIENCY

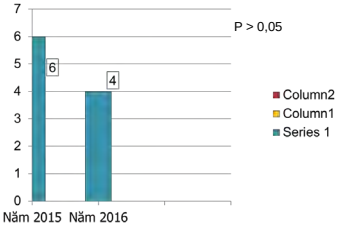
	2015		2016	
	Quantity	Percentage %	Quantity	Percentage %
Proper	33	14.0	160	78
Improper	202	86.0	45	22
Total	235	100.0	205	100.0

Reduction of 64% of patients improperly indicated antibiotics after surgery (Not including 12% following other guidelines or those with unclear evidence)
Reduction of 12,800 surgeries/year (40,000 surgeries every year)
Reduction of 12,800 x (3 to 5) = 38,400 to 64,000 days of antibiotic use

ACTIONS

- Organizing trainings
- Developing software in smart phone
- Issuing guidelines
- Monitoring
- Reporting regularly
- Providing EBM evidence

PERCENTAGE OF EARLY SSI



Nếu ĐT Android thì down theo đường dẫn: (Downloading guidelines)
https://play.google.com/store/apps/details?id=com.ionicframework.amschorgy640678 or search trên Google store
Ipad: https://itunes.apple.com/WebObjects/MZStore.woa/wa/viewSoftware?id=1070485947&mt=8 or search trên Apple store

LESSONS LEARNT

- Strong direction from MOH

+ Guidelines on antibiotics use

+ Campaign for prevention of antibiotic resistance

+ Supports from international organizations

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LESSONS LEARNT

- Consensus and determination of the Directing Board, especially the leader
- Role of QMD
- Clinical pharmacists
- Calculation of economic efficiency
- Create output products, find sponsors

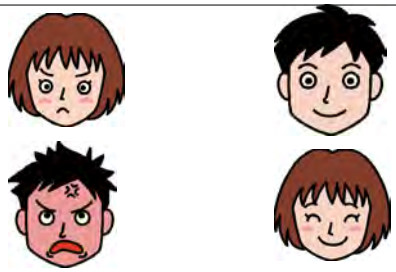
HOW TO ACHIEVE EFFECTIVENESS IN QI ACTIVITIES

- Clear division of work
- Measurable objectives
- Collaboration, not opposing
- Supportive, not trying to find others' mistakes
- Overcome barriers
- Know how to work in a team

COMMITMENT AND SUPPORT OF HOSPITAL LEADERS

Create friendly environment

What is your attitude to surrounding people?



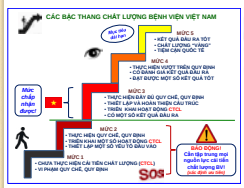
INFORMATION SHARING

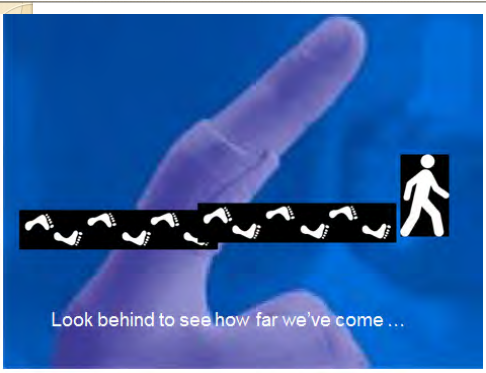
- Sharing obtained results (Contextual effects)
- Developing objectives step by step

A B C
12 B 14

LESSONS LEARNT

- Encourage CQI.
- Provide scientific evidence.
- Develop QI culture.





TAKE THE CHANCE

CPR

CONCLUSIONS

- PDCA is an effective tool for CQI
- Objectives should be short term, clear and SMART
- Conducting RCA or SWOT analysis to achieve objectives.
- Clear results should be shown to prove work effectiveness.

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THANK YOU VERY MUCH

- If you want to go fast, go alone, If you want to go far, go together.
- tonthanhtra@yahoo.com

QUALITY - CIVILIZED – MODERN - BENEVOLENT

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Session 5 How to Reduce Waiting Time?

Summary of Discussion

1. Standardization

1. Ninh Thuan Provincial General Hospital first developed their regulation on timely turnaround of laboratory test results in 2014. Previously there was no time requirement for turnaround of laboratory test results and doctors may forget or be late in treating patients. This self-development of hospital standard is a good approach to standardize hospital activities when there is no common standard.
2. Other hospitals who wish to develop their own standards on timely turnaround of laboratory test results can refer to the standard in Ninh Thuan Provincial General Hospital.

2. How Was the Timing Standard Determined?

1. The standard for timing of test turnaround in Ninh Thuan Provincial General Hospital was determined based on their actual practice, improvement expectations, consultation with practitioners, and gradual adjustment over time.
2. Meetings were organized for practitioners to discuss if the proposed timing standard was proper and feasible.
3. The hospital updated the standard continually and the current regulation is the 3rd version.

3. Timing Measurement

1. Time span of test turnaround in Ninh Thuan Provincial General Hospital is calculated in minutes between the time of the doctor's indication of tests and the time of the patient receiving test results. The data for calculation of time span is collected from the time recorded in the IT system. The IT system records the time when (i) the doctor indicates tests, (ii) the laboratory receives the samples, and (iii) the laboratory returns the results.
2. The time spans that are not measurable yet are (i) the span between the time of the doctor's indication of tests and the time of the nurse taking samples, and (ii) how long it takes a nurse to bring samples to the laboratory.
3. This timing standard applies for all inpatients within 24 hours of inpatient admission. This means it excludes any previous tests indicated before the patient is admitted as an inpatient (e.g., when the patient is in emergency department).

4. Issues for Further Considerations

1. How do we know if our self-developed standards are proper? What are possible outcomes for compliance to this timing regulation? E.g., less incidents, less complaints from patients, less complications?
2. The process from when the doctor indicates tests to when s/he receives test results consists of different small stages, for example, patient's waiting time until a nurse takes samples, time for samples transfer, etc. If we can measure more specific these stages we may know what standard we should set and where in the current process we should improve, for e.g., reducing waiting time or reducing time for transferring samples to the laboratory.

Session 5

Acceleration of Specimen Collection and Sending Test Results to Doctor within the First 24 Hours of Emergency Response

Pham Viet Thai, Phung Nhat Minh, Vo Vinh Chau, Dao Thi Ly, Ngo Thi Thuy Phuong

Ninh Thuan Provincial General Hospital

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.

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 2014, the hospital issued regulation on emergency response timing, including time for specimen collection and sending test results to doctors… during emergency response process in the hospital.

Although the hospital had sent the regulation to each healthcare worker, nurses of internal medicine departments did not meet the required time for specimen collection and sending test results to doctors for additional interventions.

In September 2016, we implemented the project "Acceleration of specimen collection and sending test results to doctors within the first 24 hours of emergency response" in internal medicine departments, contributing to improve hospital quality.

2. Implemented plan

Healthcare workers were instructed to follow standard timing of specimen collection and sending test results to doctors for additional interventions.

Compliance was checked, monitored, and studied monthly and unannounced.

3. Actual state

A survey of 600 medical records on the compliance to emergency response timing within the first 24 hours in the hospital from April to September 2015. The results show that 70% did not follow specimen collection timing; and 8.8% did not follow timing for sending test results to doctors.

4. Objective

Specimen collection and sending test results to doctors for additional interventions in internal medicine departments are accelerated in September 2016, compared with the first week of July 2016.

5. Methods

1. Subjects of the study

– Inpatients in 4 internal medicine departments (ICU, 02 internal medicine departments and Infectious Diseases Department) of Ninh Thuan Provincial General Hospital from July to September 2016.

– Exclusion: patients discharged within 24 hours after admission and those who have been admitted in less than 24 hours.

2. Establishment of measures

- Sample size: 20 medical records per week from the four departments (12 weeks from July to September 2016).

- Sampling: single random sampling by drawing lots, first choosing one day from Monday to Friday, then choosing patients in the four departments (for example, there are 15 patients in the department, make 15 lots and then randomly choose 5).

- Statistical process control:

  - Calculating average time spans for specimen collection and sending test results to doctors at 4

different emergency levels.

- Statistics: Using Excel to calculate data and draw charts.

6. Causes of prolonged specimen collection and sending test results to doctors

- There were some inappropriate points in the regulation on emergency response timing;

- Nurses working in the internal medicine departments did not know how to arrange work, which causes untimely collection of specimen (for example, sometimes nurses forgot to send specimen or to send results to doctors when they received new emergency patients);

- Test results were available at midnight, therefore sending results to doctors was delayed until morning;

- Shift handover did not include sending test results to doctors, therefore some were delayed.

- Specimen collection time increases due to incorrect time set in the computer system;

- Many patients were admitted from 18h to 23h every day, therefore only 2 nurses on duty were not able to collect specimen on time;

- Doctors forgot to check emergency classification boxes such as: emergency, urgent, semi-urgent, or non-urgent;

- Head nurses of the internal medicine departments didn't remind staff regularly about compliance to emergency response timing;

- Some nurses didn't know well the regulation on emergency response timing;

- New nurses were not trained about the regulation, their slowness slowed down the process.

7. Action plan

- Adjusting the regulation on emergency response timing and re-training nurses in internal medicine departments, especially new nurses;

- Training and implementing 5S for internal medicine departments;

- Reviewing manpower, adding 10 nurses for 2 internal medicine departments, increasing the number of nurses on night duty (03 nurses/night/80 beds);

- Head nurses regularly checking and reminding staff to comply to the regulation on timing for specimen collection and sending tests results to doctors in the daily morning meeting;

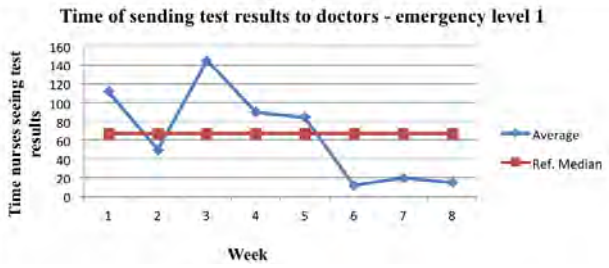
- Checking and monitoring regularly and unannounced, if any delays are detected they would be reflected in performance assessment;

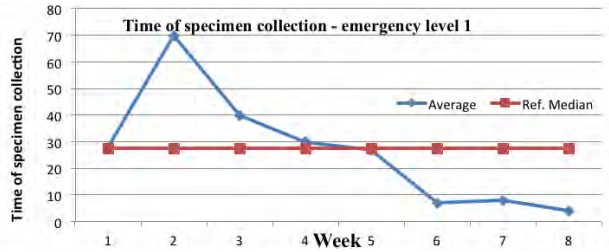
- Weekly reviewing the compliance to the regulation on timing for specimen collection and sending test results to doctors, as well as conducting RCA of incompliance.

8. Results

- Average time for specimen collection and sending test results to doctors in all emergency levels of weeks 1, 2, 3 and 4 did not meet the regulation requirements.

- After identifying some causes and conducting some interventions, average time for specimen collection was improved and stayed stable in weeks 6, 7 and 8. However, time of sending test results to doctors for additional interventions at emergency level 4 is not stable.





Level	Name	Time for doctor to examine and initially respond, since patient's admission to hospital/ department or patient's condition becomes severe	Testing time				Functional Examination (FE) Ultrasound, endoscopy, ECG		Diagnostic imaging (DI) X-ray, CT, MRI		Time for nurse to report results to doctor and doctor to give additional interventions, since FE and DI results received
			Time for nurse to collect and transport specimen, since doctor finishes examination	Time for test turnaround, since specimen received	Time for nurse to read test results and report to doctor to update the results that influence diagnosis in medical record (4)	Time for additional interventions by doctor, since test results received	Time for nurse to transfer patient to FE or arrange for bedside ultrasound, since doctor finishes examination	Time for FE turnaround, since request or patient received	Time for nurse to transfer patient to DI department or arrange for bedside X-ray, since doctor finishes examination	Time for DI turnaround, since request or patient received	
1	Emergency	Immediate	Within10 minutes (1)	≤ 40 minutes (3)	Within10 minutes	≤ 15 minutes ≤ 20 minutes if there was operation (5)	Within 15 minutes (1)	≤ 20 minutes if there was no DI (6)	Within15 minutes (1)	≤ 20 minutes if there was no FE (6)	≤ 10 minutes ≤ 20 minutes if there was operation (5)
			50 minutes is the maximum time for nurses to send test results to doctor (since laboratory receives specimen)					Maximum time for DI turnaround is 20 minutes		Maximum time for FE turnaround is 20 minutes	
For example, emergency patient is admitted at 9.00 o'clock		9h	9h10	9h50	10h00	10h15 Maximum 80 minutes if there was operation	9h15	9h35	9h15	9h35	9h45 Maximum 55 minutes if there was operation
2	Urgent	Within 05 minutes	Within 20 minutes (1)	≤ 60 minutes	≤ 25 minutes	≤ 15 minutes ≤ 30 minutes if there was operation (5)	Within 20 minutes (1)	≤ 40 minutes if there was no DI (6)	Within 20 minutes (1)	≤ 40 minutes if there was no FE (6)	≤ 15 minutes ≤ 30 minutes if there was operation (5)
			85 minutes is the maximum time for nurses to send test results to doctor (since laboratory receives specimen)					Maximum time for DI turnaround is 40 minutes		Maximum time for FE turnaround is 40 minutes	
For example, urgent patient is admitted at 9.00 o'clock		9h05	9h25	10h25	10h50	11h05 Maximum 140 minutes if there was operation	9h25	10h05	9h25	10h05	10h20 Maximum 95 minutes if there was operation
3	Semi-urgent	Within 15 minutes (2)	Within 40 minutes	≤ 120 minutes	≤ 35 minutes	≤ 30 minutes ≤ 60 minutes if there was operation (5)	Within 50 minutes	≤ 60 minutes if there was no DI (6)	Within 50 minutes	≤ 60 minutes if there was no FE (6)	≤ 30 minutes ≤ 60 minutes if there was operation (5)
			155 minutes is the maximum time for nurses to send test results to doctor (since laboratory receives specimen)					Maximum time for DI turnaround is 60 minutes		Maximum time for FE turnaround is 60 minutes	
For example, semi-urgent patient is admitted at 9.00 o'clock		9h15	9h55	11h55	12h30	13h00 Maximum 270 minutes if there was operation	10h05	11h05	10h05	11h05	11h35 Maximum 185 minutes if there was operation
4	Non-urgent	Within 20 minutes (2)	Within 60 minutes	≤ 180 minutes	≤ 40 minutes	≤ 30 minutes ≤ 90 minutes if there was operation (5)	Within 60 minutes	≤ 90 minutes if there was no DI (6)	Within 60 minutes	≤ 90 minutes if there was no FE (6)	≤ 30 minutes ≤ 90 minutes if there was operation (5)
			220 minutes is the maximum time for nurses to send test results to doctor (since laboratory receives specimen)					Maximum time for DI turnaround is 90 minutes		Maximum time for FE turnaround is 90 minutes	
For example, non-urgent patient is admitted at 9.00 o'clock		9h20	10h20	13h20	14h	14h30 Maximum 390 minutes if there was operation	10h20	11h50	10h20	11h50	12h20 Maximum 260 minutes if there was operation

Notes:

- After the patient comes to the department, the nurse must immediately receive him/her, arrange bed, measure vital signs, and invite doctor – if the doctor is away, there must be somebody else to help with inviting him/her. Time for doctor's examination and initial response is calculated since the patient is admitted.

- The doctor (or the authorized nurse) marks the appropriate box of emergency level for Laboratory, FE Department and DI Department to do their work accordingly. Staff of FE Department and DI Department must write the time of receiving patient in the indication form (with signature and full name of people who handovers and who receives).

- The regulation on timing for examination, specimen collection, test turnaround and response applies to both normal working hours and outside of normal working hours, including Saturdays, Sundays and holidays.

- The priority for para-clinical examinations is as follows: first blood tests, second FE and finally DI.

- Tests included in the emergency response procedure are: biochemistry, immunology, hematology; those listed in remark (7) below are not included.

- FE included in the emergency response procedure are: ultrasound, stomach endoscopy, electromyography, electroencephalogram, …; colonoscopy is not included.

- DI included in the emergency response procedure are: normal X-ray, including contrast X-ray such as stomach and intestinal X-ray using barite, KUB, pelvis X-ray, head CT scan with/without contrast, sinus CT scan, MRI, chest and abdominal CT scan with/without contrast.

- During patient's stay in the hospital, if laboratory tests, FE and DI are necessary, time for specimen collection, test turnaround and intervention is calculated as specified above.

- Patients at emergency level 4 still need to be indicated laboratory tests, FE and DI, except those that require empty stomach or non-emergency gastro endoscopy.

- Pediatric Emergency and ICU, Cardiovascular Internal Medicine, Gastroenterology Internal Medicine, and ICU – Toxicology Departments that have more than 01 urgent emergency case at the same time, time for testing, FE and DI will be extended by 10 minutes.

- In clinical departments, if new patients come when the doctor is taking care of patients who are in stable or non-emergency condition, the doctor must arrange his/her time to visit and examine patients according to emergency level (identified by Emergency Department or OPD) following the timing regulation.

(1) During emergency process that requires mobilization of more manpower, the doctor examines and give verbal indication for test, FE and DI. Right after that, the nurse must take specimen, if different tests are indicated 5-10ml of blood can be taken. If ultrasound and/or X-ray is indicated, the nurse must contact FE Department and/or DI Department for bedside services or transfer the patient to these departments if the patient's condition allows. In case of difficulty in taking specimen, time can be extended by 5-10 minutes, depending on each case.

(2) Nurses must receive patients immediately when they arrive at the hospital or department, explain in details and comfort patients while waiting for doctor's visit.

(3) Maximum time for taking blood gas and result turnaround is 05 minutes, for blood type test 15 minutes, for bedside X-ray 10 minutes, for some other tests can be longer.

(4) Based on the regulation on test results turnaround, nurses should actively check the results via intranet and report to the doctor for him/her to write abnormal results in the treatment sheet. However, the result paper must be attached to the medical record within 12 hours after results are available. When results are not available on the intranet, the laboratory must inform nurses to come to get the result paper following the timing regulation. If everyone is working on an emergency case, these works can be done later.

(5) If the surgery is not conducted following the timing regulation, there must be a confirmatory signature from the operation theater (OT) in the medical record about surgery delay due to lacking of OT or other problems.

(6) When both FE and DI are indicated to the patient, time is extended by 20 minutes. When 02 or more FE or DI techniques are indicated, time for each technique performance is extended by 10 minutes (if X-ray of several bones is indicated, time for technique performance on each kind of bone is extended by 05 minutes only). Time for head CT scan without contrasts is extended by 15 minutes. MRI, abdominal CT scan with contrast, head CT scan with contrast, vascular ultrasound, heart ultrasound, emergency endoscopy is extended by 40 minutes.

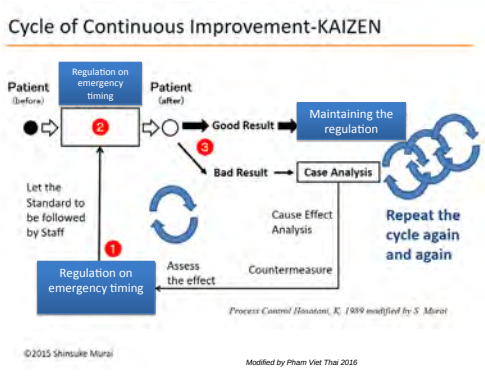
(7) Some tests not included in emergency timing are: peripheral blood smear, SLE, Pap smear, pathology, blood culture, hepatitis virus quantification.

Director:

Dr. Thai Phuong Phien, MD, 2nd Degree Specialis

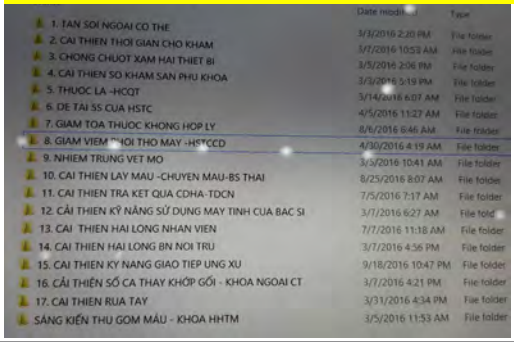
Acceleration of specimen collection and sending test results to doctors within the first 24 hours of emergency response

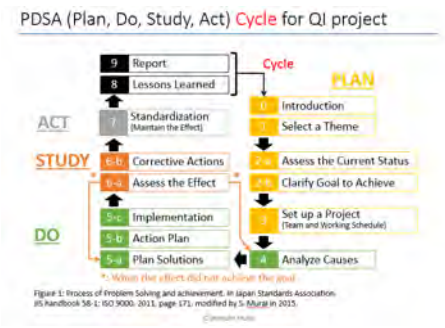
Presenter: Dr. Pham Viet Thai



SCIENTIFIC BASIS FOR IMPLEMENTATION OF QUALITY IMPROVEMENT PROJECTS IN NINH THUAN PROVINCIAL GENERAL HOSPITAL IN 2016

THE STATE OF THE HOSPITAL IN 2015, THE HOSPITAL IMPLEMENTS 17 QI PROJECTS IN 2016 SUCH AS:





Reasons for choosing the topic

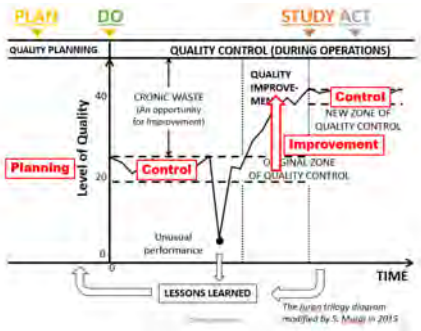
Examination, diagnosis, indication of treatment methods in a timely manner.

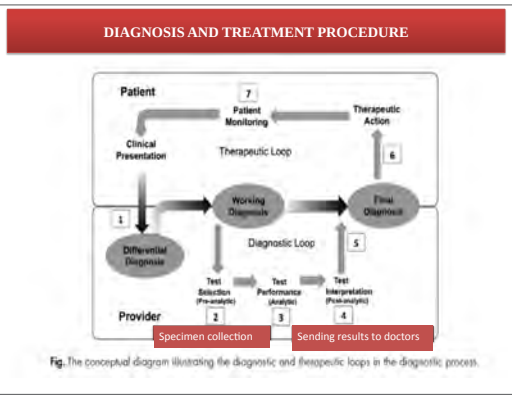
Standard A1.4, if the patient is not given emergency treatment timely, this standard will be ranked grade 1.

2016

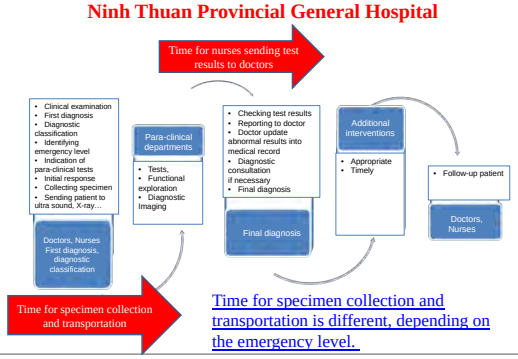
2015, not good implementation

2014, the hospital issued the regulation on emergency response time





Emergency response procedure in Ninh Thuan Provincial General Hospital



Time for specimen collection and transportation is different, depending on the emergency level.

Methods

Subject of the study:

Inpatients in 4 internal medicine departments from July to September 2016

Establishment of measures:

- Weekly survey of 20 medical records of the 4 departments (12 rounds of survey in 3 months – from July to September 2016).

SURVEY FORM

- Single random sampling
- Statistical process control:

+ Calculating average time spans for specimen collection and sending test results to doctors at 4 different emergency levels.

+ Using Excel to calculate data and draw charts.

Implemented plans

Guides — Providing guidance for staff to follow the regulation on timing standard

Supervise — Checking and monitoring the compliance to the regulation

Causes of prolonged specimen collection and sending test results to doctors:

- There were some inappropriate points in the regulation on emergency response timing;

-Nurses working in the internal medicine departments did not know how to arrange work;

- Test results were available at midnight, therefore sending to doctors was delayed until morning;

- Shift handover did not include sending test results to doctors, therefore some were delayed.

Current state

- Study by Robert Hawkins,

+ Delayed specimen collection and transportation (46-68%);

+ Delayed sending results and updating abnormal values (13-20%)

- Study by Christopher L. Roy:

41% patients received test results at discharge time,

9.4% of which were affected due to delayed para-clinical results and may sue the doctors.

Causes of prolonged specimen collection and sending test results to doctors:

- Many patients were admitted from 18h to 23h everyday, therefore only 2 nurses on duty were not able to collect specimen in time;

- Doctors forgot to check emergency classification boxes such as: most severe emergency, emergency, partly emergency, etc.

- Head nurses of the internal medicine departments didn't remind staff regularly about compliance to emergency response timing.

- Some nurses didn't know well the regulation on emergency response timing;

- New nurses were not trained about regulations, their slowness slowed down the process.

Current state

In 2015: A survey of 600 medical records on the compliance to emergency response timing within the first 24 hours in the hospital from April to September 2015

Not following specimen collection timing (70%)

Not following timing for sending test results to doctors (8.8%)

Objective

Specimen collection and sending test results to doctors for additional interventions in internal medicine departments are accelerated in September 2016, compared with the first week of July 2016.

IMPROVEMENT ACTIONS

- Adjusting the regulation on emergency response timing and re-training for nurses in the internal medicine departments, especially new nurses;
- Training and implementing 5S for the internal medicine departments;
- Reviewing manpower, adding 10 nurses for 2 internal medicine departments, increasing the number of nurses on night duty (03 nurses/night/80 beds);

IMPROVEMENT ACTIONS

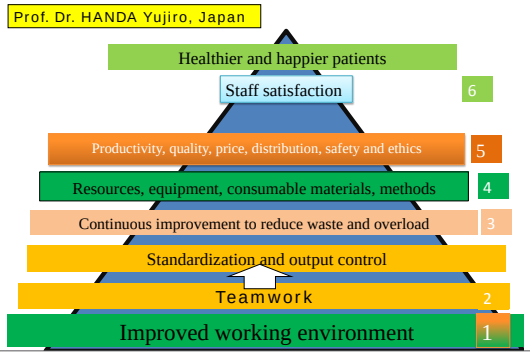
- Head nurses regularly checking and reminding staff to comply to the timing regulation on specimen collection and sending tests results to doctors in the daily morning meeting;
- Checking and monitoring periodically and unannounced, if any delays are detected they would be reflected in performance assessment;
- Weekly reviewing the compliance to the timing regulation on specimen collection and sending test results to doctors, as well as conducting RCA of incompliance.

CONCLUSIONS

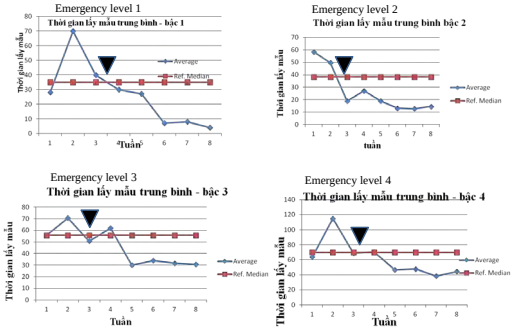
RESULTS

06 BASIC ISSUES MAKING PATIENTS SATISFIED

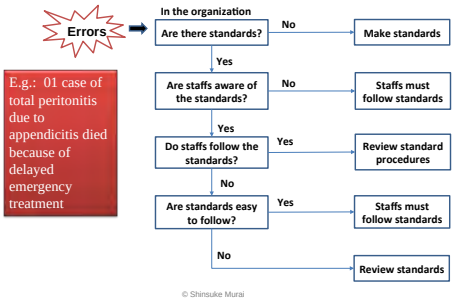
Prof. Dr. HANDA Yujiro, Japan



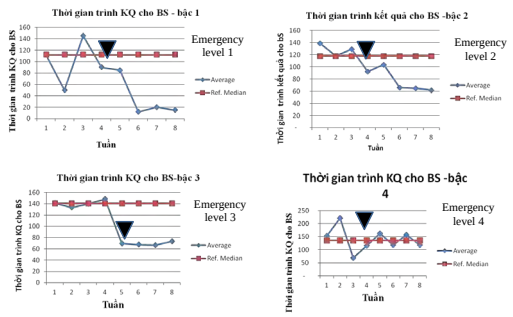
RESULTS
AFTER 8 WEEKS OF SURVEY ON SPECIMEN COLLECTION TIME



Identifying issues related to standardization and compliance to standards



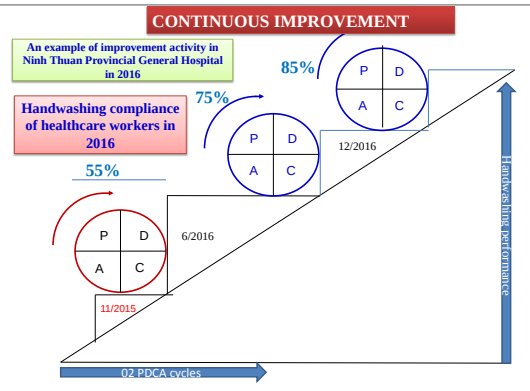
RESULTS
AFTER 8 WEEKS OF SURVEY ON TIME OF SENDING TEST RESULTS TO DOCTORS



CONTINUOUS IMPROVEMENT

An example of improvement activity in Ninh Thuan Provincial General Hospital in 2016

Handwashing compliance of healthcare workers in 2016



CONCLUSIONS

KNOWLEDGE	TRAINING
TIME	ARRANGEMENT
MANPOWER	COLLABORATION
FINANCE	PRIORITY

THANK YOU FOR YOUR ATTENTION

Session 6 The Role of Quality Management Department in Hospital

Summary Discussion

1. QMD's Supporting Role to the Hospital Director

1. QM/PS is a relatively new area for both the hospital director and QMD staff. In some hospitals, the director may lead QMD in their QM/PS work while not in some others, QMD may need to start on their own and try to convince their director to acknowledge their work and position.
2. If a QMD can propose plans/initiatives that convince the director, they are taking the role of an advisor to the director. If they cannot propose ideas or propose those that do not convince the director, they must then follow the director's ideas and in such cases they are taking the role of a helper.
3. In some hospitals, such as in Da Nang Hospital for Women and Children, the director may prefer to discuss not only with QMD but also with other departments (e.g., General Planning Department, Personnel Department) to develop strategies and plans for QM/PS in their hospital.
4. In some hospitals where QM/PS is considered very important, determining the survival of the hospital in a more and more competitive context, a competent QMD head can be expected to be promoted to a hospital top management position (vice director or director).

2. QMD's Relationship with Other Departments

1. QMDs in many hospitals were established under the requirement of MOH. At the beginning, many people, including the hospital leaders, did not know QMD's roles and functions. Some hospital staff even think that QMD staff have no work to do. However, QMD's work usually need collaboration from other departments. So asking for such collaboration can be a real challenge for QMD staff.
2. Nursing department may be the one who will work most closely with QMD in QM/PS activities. In Da Nang Hospital for Women and Children, where QM/PS just started recently (QMD was established in May 2016), the Nursing Department was among the first ones that worked with QMD. The head of Nursing Department acknowledged that by working together they created some visible small changes in the hospital.
3. Support from heads of other departments in hospital is important for implementation of QM/PS activities. For example, in Can Tho Central General Hospital, because the heads of four departments supported QMD to apply 5S in their departments, 5S has been implemented and maintained in these departments. Meanwhile, it is very difficult for QMD to apply 5S in other departments because the department heads there are not very supportive.

Session 6-1

Procedure for Handling Healthcare Complaints and Denunciations in Division of Technical Medicine and Pharmacy, Medical Services Administration

Cao Duc Phuong

Medical Services Administration, Ministry of Health

Chapter I

GENERAL PROVISIONS

Article 1. Scope of regulation

This procedure regulates all steps of the process for handling citizens' complaints and denunciations about medical services in the hospitals under the Ministry of Health (MOH) or in other healthcare institutions when citizens do not agree with previous decisions by a responsible agency.

Article 2. Applied subjects

This procedure applies to staff of Division of Technical Medicine and Pharmacy (DTMP) and complaints and denunciations by individuals or organizations following current laws.

Article 3. Principles for handling complaints and denunciations

1. Accuracy, objectivity, transparency, democracy and timely manner are assured;
2. Proper authority, procedure and timing;
3. Legal rights and benefits of collectives, organizations, agencies and individuals are respected and protected.

Article 4. Documents of reference

- Chapter VII, Law on Medical Examination and Treatment in 2009,

- Decree number 63/2012/ND-CP dated 31/12/2012 regulating functions, tasks, authority and organizational structure of the MOH

- Decision number 458/QD-BYT dated 08/02/2014 by the Minister of Health regulating functions, tasks, authority and organizational structure of Medical Services Administration (MSA).

Chapter II

PROCEDURE FOR HANDLING COMPLAINTS AND DENUNCIATIONS

Article 5. Information receiving process

- MSA Office receives complaint letters from citizens or other MOH units and submits them to MSA leaders for direction of task division.

- DTMP: after receiving order from MSA leaders, enters information in the system and assigns responsible staff to handle.

Article 6. Process for verification and handling complaints/denunciations

1. Verification and clarification of complaint and denunciation letters

1.1. For cases in which a citizen sends a complaint/denunciation letter about medical services in a hospital under MOH, a sectoral one, or a private one

- MSA sends an official document to the complained/denunciated hospital to request a report of the event. The document must state clearly that:

- If the hospital does not have a technical committee to review the event, it is required to establish one to review the event and respond to the patient, as well as report to MSA. (1)
- If the hospital has a technical committee and has already responded to the patient but he/she

continued to complain, the hospital is required to send to MSA a stamped copy of the technical committee's meeting minutes and of the patient's medical record for MSA to review. (2)

* Remark: The document must be copy sent to the patient so that he/she knows the process.

- For cases (1), if after the hospital responds to the patient, he/she does not accept and files a complaint to MOH, then follow process (2).

1.2. For cases in which a citizen sends a complaint/denunciation letter about medical services in a hospital under local Department of Health

- MSA sends an official document to the complained/ denunciated hospital to request a report of the event. The document must state clearly that:

- If Department of Health (DOH) does not have a technical committee to review the event, it is required to establish one to review the event and respond to the patient, as well as report to MSA. (1)
- If DOH has a technical committee and has already responded to the patient but he/she continued to complain, DOH is required to send to MSA a stamped copy of the technical committee's meeting minutes and of the patient's medical record for MSA to review. (2)

* Remark: The document must be copy sent to the patient so that he/she knows the process.

- For cases (1), if after the DOH responds to the patient, he/she does not accept and files a complaint to MOH, then follow process (2).

1.3. For cases in which a citizen sends a complaint/denunciation letter about medical services to a People's Court at any level and the Court sends an official document to MOH to request its conclusions of the event for consideration

- If necessary documents are attached with the Court's document, MSA proceeds as in the next section.

- If necessary documents are not attached with the Court's document, MSA sends an official document to the Court to request relevant medical record, technical committee's meeting minutes of responsible agencies for consideration.

* Remark: The document must be copy sent to the patient so that he/she knows the process.

2. Establishment of MOH Technical Committee to handle complaints and denunciations

- Study carefully medical records, meeting minutes of technical committees at all levels and relevant documents to:

- Invite one person to be the leader of the Technical Committee (Committee Chairman): who is usually prestige professor or associate professor of the specialty covering the disease being complained.
- Invite people to be members of the Technical Committee from specialties related to the patient's complaint, including functional examination, laboratory test and diagnostic imaging.

* Remark:

- Leader of MSA is a permanent Vice Chairman of the Technical Committee.

- Committee members include people from Departments of Legislation and relevant functional departments.

- A lawyer is a mandatory member of the Committee

- Secretary of the Committee is an expert from DTMP whose specialty covers the disease being complained.

- After that, submit draft Submission Form and Decision to establish the technical committee to MSA and MOH leaders for approval.

3. Technical Committee's Meeting

- After the technical committee is approved by MOH, DTMP reports to MSA leaders to schedule the committee's meeting, with approval from the committee chairman.

- Send invitations, medical records and relevant documents to committee members for study.

- Send invitation the patient's family who files the complaint to attend the committee meeting.

- Organize the committee meeting.

- Depending on the complexity of the event and the committee's consensus, one or more meetings will be held.

- After the meeting(s), the secretariat finalizes the meeting minute(s) and collect comments from the committee members before submitting to the committee chairman for signature

* Remark:

- Before the meeting day, call to confirm with the

committee members. The meeting will be held if at least two thirds of committee members are able to attend, including committee chairman, member of Department of Legislation, lawyer.

- The person who files the complaint and patient family members can attend only some sessions, which are decided by the committee.

- Call the person who files the complaint to confirm that he/she receives the invitation to avoid later complaint about not receiving the invitation.

4. Announcement of conclusions for the complaint

- MOH Technical Committee makes conclusions about whether there were technical errors in reception, emergency response, examination and treatment for the patient and specify the errors (if any). The Committee also makes recommendations and lessons learnt to fix the error(s).

- After having the committee's conclusions, MSA sends to the person who files the complaint an official document which includes these conclusions as a basis for handling the complaint according to the Law of Complaint and Denunciation. MSA also reports to MOH leaders, inspectors and Office.

Session 6-2

The Role of Quality Management Department

Duong Huy Luong, MD, PhD

Quality Management Department, Medical Services Administration, Ministry of Health

Main contents:

1. The role of the QMD and its relationship with the directing board, QM network, other departments, patients, and healthcare workers
2. The QMD's functions, tasks, and actual activities
3. The QMD's advantages and disadvantages
4. What the QMD needs to do and should do
5. Development orientations and future trends of the QMD

Detailed contents:

1. The role of the QMD and its relationship with the directing board, QM network, other departments, patients, and healthcare workers

- What is the role of the QMD? Making QI plans, implementing, monitoring?
- Important or not important role?
- Relationship with the directing board (advisor, implementer, monitor…)
- Relationship with QM network (coordinator, leader…)
- Relationship with other departments, healthcare workers (supporter, working condition facilitator…)
- Relationship with patients (listener, receiver, feedback giver…)

2. The QMD's functions, tasks, and actual activities

- Functions, tasks (according to Circular 19/2013/TT-BYT)
- Actual activities: either assigned too much work or nothing to do
- How to balance activities of the QMD?

3. The QMD's advantages and disadvantages

- Advantages: Ministry of Health's orientations, directive documents, policies; and others…
- Difficulties: old viewpoints, shortage of manpower, resistance from colleagues, huge workload, limited budget...

4. What the QMD needs to do and should do

- Building trust and passion for QI among QM staff
- Approaching new viewpoints on quality and improving QM knowledge
- Changing viewpoints of the directing board and healthcare workers
- Clarifying the scope of work and management
- Making QI plans
- Mobilizing financial resources for QI
- Instructing other departments to implement activities and monitoring
- Making products with QMD "brand"
- Measuring important indicators to evaluate the impacts of QI activities
- Other work…

5. Development orientations and future trends of the QMD

- Envisioning for the QMD
- Developing the QMD's orientations for the next 5, 10 years
- QM trends in hospitals: The QMD expands and

increases its role

- Modern private hospitals have the director (or one vice director) in charge of all hospital quality issues.

Conclusions:

Identifying clearly the QMD's roles, position, strengths, weaknesses, activities, products, and results will help the department work more effectively, contributing to improved quality and satisfaction of patients and healthcare workers.

THE ROLE OF QUALITY MANAGEMENT DEPARTMENT

Forum on Quality Management and Patient Safety

NCGM – Da Nang Hospital for Women and Children
27-29/9/2016

Dr. Duong Huy Luong, MD, PhD
Dr.Luong.kcb@gmail.com; Cellphone: 0915363369

Main contents:

- The role of the QMD and its relationship with the directing board, QM network, other departments, patients, and healthcare workers
- The QMD's functions, tasks, and actual activities
- The QMD's advantages and disadvantages
- What the QMD needs to do and should do
- Development orientations and future trends of the QMD

2

1. The role of the QMD and its relationship with the directing board, QM network, other departments, patients, and healthcare workers

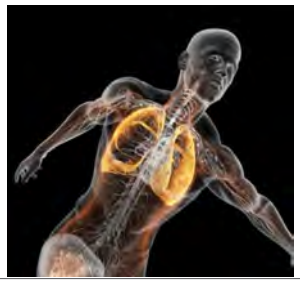
3

What is the role of the QMD?

- Important or not important role?
- Relationship with the directing board (advisor, implementer, monitor…)
- Relationship with QM network (coordinator, leader…)
- Relationship with other departments, healthcare workers (supporter, working condition facilitator…)
- Relationship with patients (listener, receiver, feedback giver…)

4

What is the role of the QMD?
Important or not important?



5

What is the role of the QMD?

6

What is the role of the QMD?

- Is part-time working good?
- Playing football and blowing whistle all in one?
- Self-monitoring?

7

"My voice echoes in the mountain, why no one answer"?

- Nobody listen?

8

"The voice" of the QMD?

- Everyone wants instruction from the QMD?
- Everyone wants to work with the QMD?

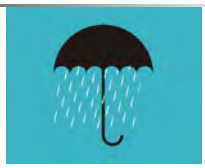
12

"The voice" of the QMD?

- Everyone must follow?
- Everyone wants to listen to the QMD?

9

As an "umbrella" covering all hospital activities, including monitoring the directing board's activities?



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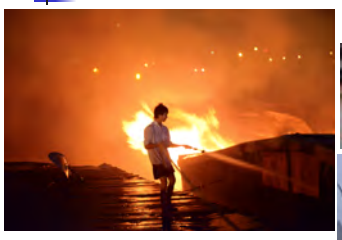
10

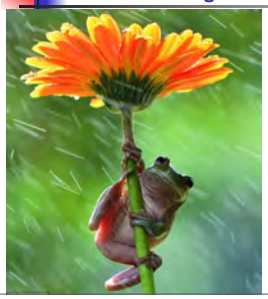
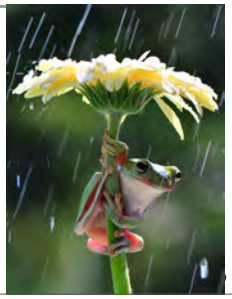
Blowing hot air to activities? Emotionally terrorizing colleagues if they don't complete work?

14

Fire fighting at hot spots?



Actively handling and overcoming difficult situations...

A referee for disputes?


Ready to protect others (healthcare workers, patients...)

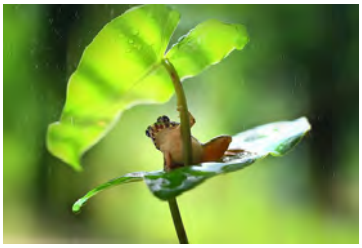
20

Monitoring, inspection, fault finding, hair splitting?


Bonding, socializing, closely collaborating with other colleagues... (understanding each other better in hardship)

21

Active, creative to create its own work, maximizing existing resources



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Identifying the role of the QMD?

- The QMD has to implement and monitor all activities by itself?

22

The QMD's functions, tasks, and activities

- Functions, tasks (according to Circular 19/2013/TT-BYT)
- Actual activities: either assigned too much work or nothing to do
- How to balance activities of the QMD?

23

The QMD's tasks

- Making plans and development orientation for the hospital's QI

24

The QMD's tasks

- "50 different aspects"

25

The QMD is assigned too many tasks, from planning for QI, implementation, monitoring other departments, to evaluation

The QMD does not know what to do ➔ play game

27

3. The QMD's advantages and disadvantages

- Advantages: MOH's orientations, directive documents, policies; and others…

28

3. The QMD's advantages and disadvantages

- Difficulties: old viewpoints, shortage of manpower, resistance from colleagues, huge workload, limited budget...

29

4. What the QMD need to do and should do

- What does the QMD need to do according to the MOH's guidance?
- What should the QMD do to improve hospital quality?

30

4. What the QMD need to do and should do

- Need to collaborate with other departments?
- What will the QMD do??
- How does the QMD affect the directing board to increase its role?
- How does the QMD affect colleagues to increase its role?
- How does the QMD affect patients to increase its role?

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4. What the QMD need to do and should do

- Building trust and passion for QI among QM staff
- Approaching new viewpoints on quality and improving QM knowledge
- **Changing viewpoints of the directing board, healthcare workers: without quality ➔ patients don't come ➔ excellent staff quit**
- Clarifying the scope of work and management
- Making QI plans

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4. What the QMD need to do and should do

- Mobilizing financial resources for QI
- Instructing other departments to implement activities and monitoring
- Making products with QMD "brand"
- Measuring important indicators to evaluate the impacts of QI activities
- Other work…

33

Important: Identifying specific products made by the QMD with measurable outputs!

34

5. Development orientations and future trends of the QMD

- Envisioning for the QMD
- Developing the QMD's orientations for the next 5, 10 years
- QM trends in hospitals: The QMD expands and increases its role
- Modern private hospitals has the director (or one vice director) in charge of all hospital quality issues

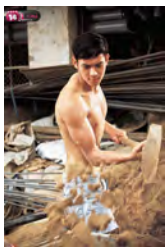
35

Conclusions:

- Identifying clearly the QMD's roles, position, strengths, weaknesses, activities, products, and results will help the department work more effectively, contributing to improved quality and satisfaction of patients and healthcare workers.

36

Be work, be stronger!



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Be think, be smarter…

38

Be others, be together, be one team, get more success!

Dr. Duong Huy Luong, Deputy Head of Quality Management Department, Medical Services Administration
Dr.Luong.kcb@gmail.com; Cellphone 0915363369

DISCUSSION (the most interesting part is in your hand)

- What is the role of QMD?
- ***Would you please share experience in:***
- How to increase the role of QMD?
- How to mobilize people for QI?
- How to inspire people to be active in QI?

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Session 7 What Can the Hospital Director Do to Promote QM/PS?

Summary of Discussion

1. The Roles of the Hospital Director in QM/PS

1. In Vietnam, compared with other areas in hospital management, QM/PS is relatively new. Therefore, it may take some time for hospital directors to understand its concepts and scope of work. In many hospitals, QMD was established under the requirement of MOH. At the beginning, hospital leaders were not clear about QMD's roles and what it should do. In these hospitals, the director might not know where to start their QM/PS work.
2. Once the hospital director has some basic understandings of QM/PS, he/she can employ a PDCA approach to QM/PS, according to experience of the director of An Giang Hospital of Obstetrics, Gynecology and Pediatrics:
   a. Orient (= Plan): The hospital director should take lead in QM/PS development in a hospital, creating a path for hospital staff to follow. If this task is led by a vice director, it may be less convince to staff. In the future, one vice director can take charge of QM/PS.
   b. Direct implementation (= Do): It is very important that the hospital director not only orients but also directs QM/PS activities by himself/herself. Some directors actually only orient (in words) but refuse to involve directly in QM/PS management due to business with other activities.
   c. Check: Once the hospital director directs QM/PS activities, he/she should regularly check if his/her staff really implement them. If they do not, the director needs to push. In such way it can help QM/PS gradually become routine in the hospital.
   d. Improve (= Act): After checking implementation, the hospital director may want to orient his/her staff to improve their QM/PS activities.
3. QM/PS is not a separate area in hospital management, but it crosses many other areas, such as clinical work, infrastructure, equipment management, etc. A director with good understanding of QM/PS can direct his/her staff to integrate safety practices in their daily work. For example:
   a. In An Giang Hospital of Obstetrics, Gynecology and Pediatrics, to enhance clinical quality, the director oriented his staff to prioritize some tasks to avoid some common mistakes and increase safety, such as (i) Update treatment protocols; (ii) Develop procedures for patient identification, newborn identification; (iii) Control safe and rational use of drugs.
   b. The director of Da Nang Hospital for Women and Children asked all of his staff to manage some time to attend this Third Forum on Hospital Quality Management and Patient Safety to start learning basic concepts and issues in QM/PS so that they can join in the hospital's QM/PS activities in the future.
4. If a hospital director recognizes the roles of QM/PS in hospital development, he/she can support QMD development, such as choosing a competent and committed person to lead the QMD, sending QM staff to QM/PS trainings and workshops, etc.
5. The hospital director should specify their own quality expectations based on their unique context. For example, a hospital in Northwestern Vietnam may receive a lot of H'mong patients who cannot speak Vietnamese. For this hospital, the director may want to prioritize enhancement of communication between H'mong patients and Vietnamese doctors over other common quality improvement activities.
6. Is the hospital director the most important factor in developing QM/PS in a hospital?
   a. The hospital director's role in QM/PS development in a hospital is significant, because if the hospital leader doesn't know where the hospital is going, how can his/her staff have a way to go?
   b. However, the director alone cannot improve hospital quality and patient safety. He/she needs help from QMD as well as other departments to do the job.

Session 7-1

Fulfilling the Role of the Hospital Director to Improve Quality Management and Patient Safety

Pham Huu Thuong[1], Nguyen Trong Khoa[2]

1 Ha Noi Lung Hospital, 2 Medical Services Administration, Ministry of Health

General contents:

1. The role of the hospital director in QM/PS
2. Advantages and difficulties in fulfilling the role of Ha Noi Lung Hospital Director in QM/PS
3. Some QM/PS achievements and next plans in Ha Noi Lung Hospital

Detailed contents:

Part I. The role of the hospital director in QM/PS

1. Concepts of leadership and leader, management and leadership, model leader

The leader's products are "right and valid decisions, feasible and effective plans".

2. Qualifications a leader (hospital director) must include: vision, inspiration, influence and 03 essential skills (understanding, social relationship and executive ability)

To create the director's dignity, which is:

- ***Ability to adapt to environment, sensibility, flexibility and creativity to create a vision for the hospital/department***
- ***Consistency and trust***

3. What the leader should avoid:

- The top 10 mistakes of the leader
- 7 common mistakes of the leader

4. The hospital director's commitment with QI

- General idea: Deming (1984) stated that there is no quality in the organization without the highest manager's commitment. His words were "if you cannot come do not send anyone else".
- 10 commitments of the hospital director in QI

5. Implementation of Circular No. 19/2013/TT-BYT on "Guidance to quality management of examination and treatment services in hospital". Pay special attention to Article 10: Organization of quality management system in hospital.

Part II. Advantages and difficulties in fulfilling the role of Ha Noi Lung Hospital Director in QM/PS

1. Five advantages

- Consistent leadership and implementation
- QM staff have knowledge, skills, enthusiasm and are responsible
- Considerable international cooperation scientific research
- High prestige and trust
- Supports from Ha Noi Department of Health

2. Seven difficulties

- Infrastructure
- Financial mechanisms
- Staff's satisfaction with current hospital quality
- Staff's "bad" habits in performing daily professional tasks
- Punishment and reward mechanism is old-fashioned.
- Safety for healthcare workers when unsafe incidents happen to patients.
- Subsidy remains because of the hospital's current

disease pattern: TB is a social disease, which needs state budget to ensure high services for TB patients (donors' supports have decreased significantly or no longer exist).

Part III. Some QM/PS achievements and next plans in Ha Noi Lung Hospital

1. Priorities and rationale

10 priorities for implementation to ensure hospital quality

2. Achievements and next plans

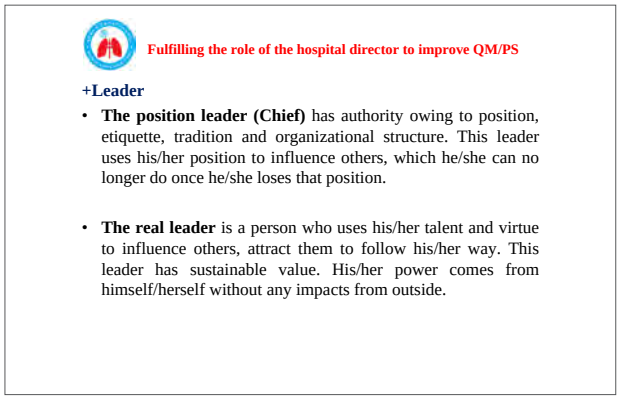
- Initial results of 5S implementation in Microbiology Department: Achieved 3* under laboratory quality evaluation according to U.S. CDC's criteria
- Next activities
- In Microbiology Department: Continuing improvement and quality enhancement to reach ISO 15189 standards
- Implementing 5S in Pharmacy Storage, drug cabinets and medical materials storage in clinical departments…

*Objective: Services quality and patient safety in Ha Noi Lung Hospital reach higher levels.


FULFILLING THE ROLE OF THE HOSPITAL DIRECTOR
TO IMPROVE QUALITY MANAGEMENT
AND PATIENT SAFETY

Presenter:
Dr. Pham Huu Thuong, MD, MPH
Director, Ha Noi Lung Hospital
Supporter and informant:
Dr. Nguyen Trong Khoa, MD, MSc
Vice Director, Medical Services Administration, Ministry of Health

I. CONTENTS:
1. The role of the hospital director in QM/PS
2. Advantages and difficulties in fulfilling the role of Ha Noi Lung Hospital Director in QM/PS
3. Some QM/PS achievements and next plans in Ha Noi Lung Hospital


Fulfilling the role of the hospital director to improve QM/PS

+Leader

- **The position leader (Chief)** has authority owing to position, etiquette, tradition and organizational structure. This leader uses his/her position to influence others, which he/she can no longer do once he/she loses that position.
- **The real leader** is a person who uses his/her talent and virtue to influence others, attract them to follow his/her way. This leader has sustainable value. His/her power comes from himself/herself without any impacts from outside.


Fulfilling the role of the hospital director to improve QM/PS

DETAILED CONTENTS

PART I. THE ROLE OF THE HOSPITAL DIRECTOR IN QM/PS

1. Concepts of leadership and leader:

+Leadership:

- Jones and Jeoge: "Leadership is a process in which a person creates impacts on others, promotes, encourages, and directs activities so that the group or organization achieves its objectives".
- According to former Vice Prime Minister Vu Khoan: "*A leader is a person who set objectives and lead people to reach such objectives. To lead people, you have to make them follow you voluntarily. If you use power to force them to follow you, they will only pretend to do so. If you want them to follow you voluntarily, people must be attracted by your intelligence and dignity*".


Fulfilling the role of the hospital director to improve QM/PS

Concepts of Management and Leadership

Management	Leadership
Is about authority	Is about influence (charisma)
A manager can be a leader	A leader is not always a manager
Copes with complication	Copes with changes
Complies to laws and regulations	Does things right
Concentrates on products	Concentrates on human

A model leader

- Listen
- Empathy
- Attitude
- Dream-Decisive
- Effective
- Resilient
- Sense of purpose
- Humility
- Integrity
- People skills

The leader's products: right and valid decisions, feasible and effective plans.

Fulfilling the role of the hospital director to improve QM/PS

Three essential skills of the leader:

+ Understanding
+ Social relationship
+ Executive ability

⇨ **Create the Director's dignity**

- ***Ability to adapt to environment, sensibility, flexibility and creativity to create a vision for the hospital/department***
- ***Consistency and trust***

Fulfilling the role of the hospital director to improve QM/PS

Three qualifications the (hospital) leader must have

1. Vision:

Is a positive image of the organization's future which every member believes in and wants to make it become true.

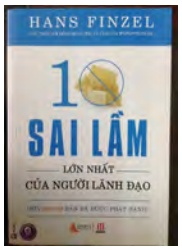
Creating vision is the main job of the leader. The leader must know where to lead the organization to, must imagine a future for the organization.

Four levels of vision (John C. Maxwell)

1. Some people never see it (they are wanderers)
2. Some people see it but don't pursue it (they are followers)
3. Some people see it and pursue it (they are successors)
4. **Some people see it, pursue it and help other people see it *(they are leaders).***

Fulfilling the role of the hospital director to improve QM/PS

What the leader should avoid (Hospital director)



The top 10 mistakes

1. **The top-down attitude**
2. **Putting paperwork before people work**
3. **The absence of affirmation**
4. **No room for mavericks**
5. **Dictatorship in decision making**
6. **Dirty delegation**
7. **Communication chaos**
8. **Missing the clues of organizational culture**
9. **Success without successors**
10. **Failure to focus on the future**

Fulfilling the role of the hospital director to improve QM/PS

2. Inspiration:

When developing a vision, the leader has to inspire others to follow and implement it. If the vision is not communicated to others and not implemented, it will be meaningless. Therefore, the second job of the leader is to inspire others.

Fulfilling the role of the hospital director to improve QM/PS

What the leader should avoid (Hospital director)

07 common mistakes

1. **Not listening, inquiring, scrutinizing and assigning tasks**
2. **Taking the job passively**
3. **No proper guidance to the team**
4. **No consideration of motivation**
5. **Playing an important role as an implementer – not as a leader**
6. **No attention to emotion**
7. **No appreciation**

Fulfilling the role of the hospital director to improve QM/PS

3. Influence

- **John C. Maxwell: "leadership is to influence (the ability to win people's hearts)." One cannot be a leader if he/she has no influence, and influence comes from the leader's power.**
- **"Best investments for the future is to create good impacts from today"**
- **To influence is a skill that can be developed.**

Fulfilling the role of the hospital director to improve QM/PS

The Hospital Director's commitment in QI

A. General idea:

Deming (1984) stated that there is no quality in the organization without the highest manager's commitment. His words were "*if you cannot come do not send anyone else*".

B. Ten commitments:

1. **Declaring quality visions, policies and objectives consistent with hospital goals.**
2. **Leading the hospital as a role model with people's trust (attending and giving supportive speech at quality seminars)**
3. **Communicating the hospital's orientations and values in providing quality medical services.**

Fulfilling the role of the hospital director to improve QM/PS

B. Ten commitments (cont'd):

4. Participating in quality projects, looking for new methods and solutions, actively working to improve hospital quality.
5. Actively receiving feedback on the effectiveness and efficiency of QI activities.
6. Identifying activities and medical services that increase hospital's prestige.
7. Identifying supporting processes that influence medical services' effectiveness and efficiency.
8. Creating an environment that encourages everyone's participation and development. For example, acknowledging staff's efforts and achievements in hospital QI.
9. Providing necessary structure and resources to support strategic plans of the hospital/departments.
10. Discovering and appointing a capable, reliable, and skillful person to take charge of QM.

Fulfilling the role of the hospital director to improve QM/PS

PART III. SOME QM/PS ACHIEVEMENTS AND NEXT PLANS IN HA NOI LUNG HOSPITAL

***General objective:**

Services quality and patient safety in Ha Noi Lung Hospital reach higher levels.

***Specific objectives:**

+ 5S implemented in departments

+ Medical safety ensured in departments

+ Hospital quality managed

Fulfilling the role of the hospital director to improve QM/PS

Implementation of Circular No. 19/2013/TT-BYT on "Guidance to quality management of examination and treatment services in hospital".

Article 10: *Organization of quality management system in hospital*

1. QM system in hospital includes: QM council chaired by the hospital director and vice-chaired by the vice director in charge of professional activities; QM department/unit; full-time QM staff; QM network suitable with hospital size.
2. Hospitals at special and 1st levels establish QMD; other hospitals establish QM department or unit depending on their own sizes, conditions and needs. QM department/unit collaborates closely with functional departments to fulfill QM tasks.
3. QM network: is established from the hospital to department levels, with QM department/unit as the coordinator.

Fulfilling the role of the hospital director to improve QM/PS

10 priorities:

1. Sufficient high quality staff
2. Good infrastructure
3. Modern medical equipment
4. Sufficient supply of drugs and consumable materials
5. Staff's average income is increased
6. Good communication and behaviors
7. Ensured medical safety
8. 5S implementation
9. Good hospital management
10. Good security

Fulfilling the role of the hospital director to improve QM/PS

Article 10: *Organization of quality management system in the hospital.*

4. QM council's activities :

a) The chairman assigns tasks to members and develops the council's working regulations;

b) The chairman establishes QM system, develops and issues documents on QM in the hospital;

c) The council organizes regular and ad-hoc meetings to support, monitor and give recommendations for QM.

5. Organization and tasks of the council and QM department/unit; tasks and authority of QM department/unit's chief and staff, members of QM network follow the guidance under Article 11, Article 12, Article 13, Article 14, Article 15 in this Circular.

Fulfilling the role of the hospital director to improve QM/PS

Selection of 5S and reasons:

- Hospital quality assurance activities are implemented according to the "Hospital Quality Standards" issued by the MOH in 2013. In 2015, the hospital scored 3.75/5.00 (raking good because there were no items scored 01 or 02)
- Departments are actually badly organized
- Incidents happen to patients (statistics is however not available)
- Damage and discard of medical materials, drugs and medical equipment still happen
- Traffic jam and narrow working environment in departments are common.

Fulfilling the role of the hospital director to improve QM/PS

PART II. SHARING DIFFICULTIES AND ADVANTAGES OF HA NOI LUNG HOSPITAL

1. Five advantages:

+ Consistent leadership and implementation
+ QM staff have knowledge, skills, enthusiasm and are responsible
+ Considerable international cooperation scientific research
+ High prestige and trust
+ Supports from Ha Noi DOH

2. Seven difficulties:

+ Infrastructure
+ Financial mechanisms
+ Staff's satisfaction with current hospital quality
+ Staff's "bad" habits in performing daily professional tasks
+ Punishment and reward mechanism is old-fashioned.
+ Safety for healthcare workers when unsafe incidents happen to patients.
+ Subsidy remains because of the hospital's current disease pattern: TB is a social disease, which needs state budget to ensure high services for TB patients (donors' supports have decreased significantly or no longer exist).

Fulfilling the role of the hospital director to improve QM/PS

Selection of 5S and reasons (cont'd):

+ 5S is valuable in ensuring medical safety, especially PS, and is the core of hospital quality

+ 5S implementation doesn't depend much on basic factors such as technical/professional qualification, medical equipment, infrastructure, income, etc.

+ High feasibility and high chance of success.

Fulfilling the role of the hospital director to improve QM/PS

***Initial results of 5S implementation in Microbiology Department:**

+ Why Microbiology Department: because the department has been implementing the project "Improvement of laboratories towards standard" under EXPAND-TB Project, supported by FIND–CDC.

+ Results: Achieved 3* under laboratory quality evaluation according to U.S. CDC's criteria.

***Next activities:**

+ In Microbiology Department: Continuing improvement and quality enhancement to reach ISO 15189 standards

+ Implementing 5S in Pharmacy Storage, drug cabinets and medical materials storage in clinical departments…

Fulfilling the role of the hospital director to improve QM/PS

The plans having been implementing:

Contents

1. Administrative management

+ Establishing Steering Committee

+ Establishing an implementation team and recruiting staff

+ Establishing a network and recruiting staff

2. Making and approving a plan

3. Training

4. Implementation

5. Evaluation, application and maintenance (standardization)

6. Procurement of necessary materials

Fulfilling the role of the hospital director to improve QM/PS

Tentative results

1.From October 1 to December 31, 2016, 5S is implemented in Biochemistry Department, Hematology and Blood Transfusion Department, Pharmacy Department, Medical Equipment Department and Outpatient department.

2.From January 1 to June 30, 2017, 5S is implemented for drug cabinets and medical materials storage in clinical departments

3.From July 1 to December 31, 2017, 5S is implemented in other departments and units

Implementation at the same time

***Medical Safety Assurance* from October 1, 2016**

Fulfilling the role of the hospital director to improve QM/PS

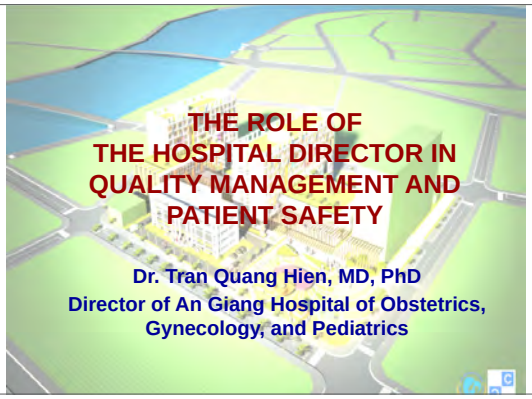
Thank you very much!

Session 7-2

The Role of the Hospital Director in Quality Management and Patient Safety

Tran Quang Hien

An Giang Hospital of Obstetrics, Gynecology and Pediatrics



Overview of An Giang Hospital of Obstetrics, Gynecology, and Pediatrics

- Provincial, 2nd level hospital. 300 beds
- Mostly financially independent
- Opened in 10/4/2016
- 12,000 outpatient turns/month (35% with health insurance)
- Bed occupancy rate: 110%
- 25 surgeries/day
- 20 normal deliveries/day

1. The role of the hospital director

- Give directions for QM/PS activities
- Preside the implementation
- Check and monitor QM/PS activities
- Give orientation for improvement of QM/PS

2. Working areas

1. Effective leadership and management
2. Quality human resource
3. Appropriate medical equipment and facilities
4. Ensured professional quality
5. QM/PS system

2.1. Leadership and management

- Compliance to legal regulations; application of the Hospital Quality Standards by the MOH
- Implementing QM models such as ISO 9001, ISO 15189…
- Developing hospital's mission, quality policy, plans, projects, and management procedures in a transparent manner as a basis for hospital quality culture.
- Developing PS procedures
- Monitoring compliance to procedures

2.2. Quality human resource

- Verifying diplomas and practising certificates of doctors and healthcare workers; monitoring and evaluate staff's professional skills
- There must be job descriptions, individual CVs and working orientation for staff
- Providing trainings for healthcare workers
- Health protection and safety program for staff

2.3. Medical equipment and facilities

- Ensured safe and effective buildings
- Safe electricity system, with good reserve power system; Sufficient, effective and safe water supply system;
- Proper disposal of solid and liquid medical waste;
- Infection control program

2.4. Ensured professional quality

- Issuing treatment protocols with regular updates; Patients are guided to participate in the treatment process (clinical pathways); Assessing doctors' and nurses' professional capacity
- Accurate patient identification procedures
- Accurate laboratory test services (ISO 15189); accurate diagnostic imaging;
- Safe and proper drug use; proper use of anesthesia and analgesics;
- Surgery services appropriate to patient's needs

2.5. Quality and patient safety improvement system

- Establishing QMD and Customer Service Department
- Establishing incident reporting system with incident analysis; establishing a system to receive and handle customer complaints
- Establishing monitoring procedures for high-risk patients
- Customer Service Department monitor patient and staff satisfaction with analysis for improvement
- Quality and PS communication system for staff

3. Implementation in An Giang Hospital of Obstetrics, Gynecology, & Pediatrics

3.1. Leadership and management

- Operating license issued for the hospital
- Examination procedures for patients with health insurance following regulations
- Implementation of Circular 19/2013/TT-BYT on quality management
- Implementation of ISO 9001, 15189 for laboratories
- Master plan for hospital development by 2020, with orientation to 2030 developed
- Procedures are developed, their compliance checked and monitored

3.2. Quality human resource

- Doctors, nurses, technicians… with postgraduate degrees and years-long experience
- Healthcare workers have proper practising certificates; nursing contests organized
- Continuous trainings for skill improvement
- Health protection and safety program implemented for staff

3.3. Medical equipment and facilities

- Buildings were renovated to be appropriate with specialty activities
- Electricity, water and oxygen supply systems work effectively
- Proper treatment of solid and liquid medical waste, as well as trash

3.4. Professional capacity

- Treatment protocols are updated timely
- Procedures for patient identification, prevention of wrong surgeries; prevention of incorrect newborn identification
- Safe, proper, and effective drug use (ABC/VEN)
- Surgical services with reasonable costs

3.5. QM/PS System

- QM Unit and Customer Service Unit were established
- IRS was established
- Customer complaints system was established
- Analysis, evaluation of patient satisfaction
- Website, fanpage, and email are used for communication on QM/PS.

4. Conclusions

Implementation of QM/PS is the most effective when the director can identify his roles and responsibilities.

Forum Outline

2nd Vietnam Forum on Quality Management and Patient Safety
Da Nang, Vietnam, 2016

Introduction:

The Vietnam Forum on Quality Management and Patient Safety is one of the three main activities of the project Strengthening Management Capability for Quality and Safety in Healthcare, under the Program for International Promotion of Japan's Healthcare Technologies and Services, funded by Japan's Ministry of Health, Labor and Welfare.

The project is implemented by National Center for Global Health and Medicine (NCGM) with assistance from NCGM – Bach Mai Hospital Medical Collaboration Center (MCC). The co-host of the second Forum (September 2016) is Da Nang Hospital for Women and Children.

Objectives:

1. To share experience of achievements and challenges in hospitals;
2. To discuss practical solutions to tackle challenges; and
3. To enhance communication among graduates and their colleagues who are interested in quality and safety in healthcare.

Venue:

Da Nang Hospital for Women and Children, Da Nang City, Vietnam

Program:

27/09/2016 (Tuesday)	Hospital tour
28/09/2016 (Wednesday)	Presentations and discussion (Day 1)
29/09/2016 (Thursday)	Presentations and discussion (Day 2)

Program

Program 28/09/2016	
08:00 - 08:30	Reception and registration
08:30 - 08:35	Welcome speech by the Director of Da Nang Hospital for Women and Children
08:45 - 09:00	Forum objectives - Dr. Shinsuke Murai (NCGM)
Session 1	**How to implement 5S effectively?**
09:00 - 09:15	**5S implementation in clinical and paraclinical departments: Results and lessons learnt** *Dr. Le Viet Nho, Quang Nam Central General Hospital*
09:15 - 09:30	**Evaluation of 5S implementation in National Hospital for Obstetrics and Gynecology** *Dr. Vu Van Du, National Hospital for Obstetrics & Gynecology*
09:35 - 10:15	**Evaluation report on 5S implementation in Thai Nguyen Central General Hospital** *Dr. Dang Hoang Nga, Thai Nguyen Central General Hospital*
09:45 - 10:00	Coffee break
10:00 - 10:15	**Results of 5S implementation in Thai Binh Provincial General Hospital: Advantages and difficulties** *Dr. Tran Thi Quynh Anh, Thai Binh Provincial General Hospital*
10:15 - 10:30	**Challenges in 5S implementation in Ha Dong General Hospital** *Dr. Nguyen Thi Huong Lien, Ha Dong General Hospital*
10:30 - 11:30	Discussion
11:30 - 13:00	Lunch
Session 2	**How to make incident reporting system work?**
13:00 - 13:15	**Initial results of implementing incident reporting system in Quy Hoa National Leprosy & Dermatology Hospital** *Dr. Nguyen The Toan, Quy Hoa National Leprosy & Dermatology Hospital*
13:15 - 13:30	**Failures in operating incident reporting and management system** *Dr. Phan Anh Phong, Ha Nam Provincial General Hospitall*
13:00 - 13:15	**The incident management journey in Tu Du Hospital** *Dr. Tran Nguyen Nhu Anh, Tu Du Hospital*
13:45 - 14:45	Discussion
14:45 - 15:00	Coffee break
Session 3	**Guidelines in hospital**
15:00 - 15:15	**Experience in improving hospital guideboard system** *Ms. Huynh My Thu, Thu Duc District Hospital*
15:15 - 16:00	Discussion

Program 29/09/2016	
Session 4	**How to ensure quality and safety in clinical work?**
08:30 - 08:45	**Surgical safety in Bach Mai Hospital** *Dr. Nguyen Thi Huong Giang, Bach Mai Hospital*
08:45 - 09:00	**Some experience in implementing surgical safety checklist in Ha Tinh Provincial General Hospital** *Dr. Hoang Song Hao, Ha Tinh Provincial General Hospital*
09:00 - 09:15	**Actual state of applying surgical safety checklist in Hue Central Hospital** *Dr. Phan Hai Thanh, Hue Central Hospital*
09:15 - 09:30	**Applying PDCA to continuous quality improvement: An example in microbial stewardship in Cho Ray Hospital** *Dr. Ton Thanh Tra, Cho Ray Hospital*
09:30 - 10:30	Discussion
10:30 - 10:45	Coffee break
Session 5	**How to reduce waiting time?**
10:45 - 11:00	**Acceleration of specimen collection and sending test results to doctors within the first 24 hours of emergency response** *Dr. Pham Viet Thai, Ninh Thuan Provincial General Hospital*
11:00 - 11:45	Discussion
11:45 - 13:00	Lunch
Session 6	**The role of quality management department in hospital**
13:00 - 13:15	**Procedure for handling healthcare complaints and denunciations in Department of Medical and Pharmaceutical Professional Qualification Management (MOH)** *Dr. Cao Duc Phuong, Medical Services Administration, Ministry of Health*
13:15 - 13:30	**The role of quality management department** *Dr. Duong Huy Luong, Medical Services Administration, Ministry of Health*
13:30 - 14:15	Discussion
14:15 - 14:30	Coffee break
Session 7	**What can the hospital director do to promote QM/PS?**
14:30 - 14:45	**Fulfilling the role of the hospital leader to improve quality management and patient safety** *Dr. Pham Huu Thuong, Hanoi Lung Hospital*
14:45 - 15:00	**The role of the hospital director in quality management and patient safety** *Dr. Tran Quang Hien, An Giang Hospital of Obstetrics, Gynecology and Pediatrics*
15:00 - 15:45	Discussion
15:45 - 16:00	Closing - Dr. Duong Huy Luong

Organization

Da Nang Hospital for Women and Children:

Dr. Tran Dinh Vinh, MD, PhD, Director

Dr. Thai Thi Thanh Thuy, MD, 2nd Degree Specialist, Deputy Head of Quality Management Department

Dr. Huynh Thi Bich Ngoc, MD, 2nd Degree Specialist, Head of Department of Direction of Healthcare Activities - Training and International Cooperation

Session 1: How to implement 5S effectively?

Chairs:

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

Dr. Tran Nguyen Nhu Anh, MD, MSc, Deputy Head of Quality Management Department, Tu Du Hospital

Presenters:

Dr. Le Viet Nho, MD, PhD, Vice Director, Quang Nam Central General Hospital

Dr. Vu Van Du, MD, PhD, Head of Quality Management Department, Head of Treatment Services Department, National Hospital of Obstetrics and Gynecology

Dr. Dang Hoang Nga, MD, MSc, 2nd Degree Specialist, Head of Quality Management Department, Vice Director of Center for Training – Direction of Healthcare Activities, Thai Nguyen Central General Hospital

Dr. Tran Thi Quynh Anh, MD, 1st Degree Specialist, Deputy Head of Quality Management Department, Thai Binh Provincial General Hospital

Dr. Nguyen Thi Huong Lien, MD, MSc, 2nd Degree Specialist, Head of Quality Management Department, Ha Dong General Hospital

Session 2: How to make incident reporting system work?

Chairs:

Dr. Le Viet Nho, MD, PhD, Vice Director, Quang Nam Central General Hospital

Ms. Huynh My Thu, MSc, Head of Quality Management Department, Thu Duc District Hospital

Presenters:

Dr. Nguyen The Toan, MD, PhD, Head of General Planning Department, Quy Hoa Central Leprosy – Dermatology Hospital

Dr. Tran Nguyen Nhu Anh, MD, MSc, Deputy Head of Quality Management Department, Tu Du Hospital

Session 3: Guidelines in hospital

Chairs:

Dr. Vu Van Du, MD, PhD, Head of Quality Management Department, Head of Treatment Services Department, National Hospital of Obstetrics and Gynecology

Dr. Tran Thi Quynh Anh, MD, 1st Degree Specialist, Deputy Head of Quality Management Department, Thai Binh Provincial General Hospital

Presenter:

Ms. Huynh My Thu, MSc, Head of Quality Management Department, Thu Duc District Hospital

Session 4: How to ensure quality and safety in clinical work?

Chairs:

Dr. Tran Quang Hien, MD, PhD, Director, An Giang Hospital of Obstetrics, Gynecology and Pediatrics

Dr. Phan Hai Thanh, MD, PhD, Head of Quality Management Department, Deputy Head of Abdominal Surgery Department, Hue Central Hospital

Presenters:

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

Dr. Hoang Song Hao, MD, 1st Degree Specialist, Head of Quality Management Department, Ha Tinh Provincial General Hospital

Dr. Phan Hai Thanh, MD, PhD, Head of Quality Management Department, Deputy Head of Abdominal Surgery Department, Hue Central Hospital

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

Session 5: How to reduce waiting time?

Chairs:

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

Dr. Dang Hoang Nga, MD, MSc, 2nd Degree Specialist, Head of Quality Management Department, Vice Director of Center for Training – Direction of Healthcare Activities, Thai Nguyen Central General Hospital

Presenters:

Dr. Pham Viet Thai, MD, 1st Degree Specialist, Head of Quality Management Department, Ninh Thuan Provincial General Hospital

Session 6: The role of quality management department in hospital

Chairs and Presenter:

Dr. Duong Huy Luong, MD, PhD, Deputy Head of Quality Management Department, Medical Services Administration, Ministry of Health

Session 7: What can hospital director do to promote QM/PS?

Chairs:

Dr. Duong Huy Luong, MD, PhD, Deputy Head of Quality Management Department, Medical Services Administration, Ministry of Health

Dr. Tran Dinh Vinh, MD, PhD, Director, Da Nang Hospital for Women and Children

Dr. Le Hong Trung, MD, MSc, Director, Vinh Phuc Provincial General Hospital

Presenters:

Dr. Pham Huu Thuong, MD, MPH, Director, Hanoi Lung Hospital

Dr. Tran Quang Hien, MD, PhD, Director, An Giang Hospital of Obstetrics, Gynecology and Pediatrics

Coordinator:

Dr. Shinsuke Murai, DDS, PhD, NCGM

Mr. Jun Moriyama, RN, MSN, NCGM

Secretariat:

Ms. Nguyen Hong Anh, MSc, MCC

Ms. Le Thi Thu Phong, MCC

Dr. Nguyen Thi Le Hang, MD, PhD, MCC

Ms. Pham Thi Phuong Thuy, MPH, MCC

Hospital Tour Program

Program 27/09/2016	
08:30 - 09:00	**Welcome and Introduction**
08:30 - 08:40	Welcome speech by the Director of Da Nang Hospital for Women and Children
08:40 - 08:50	Introduction by Department of Quality Management
08:50 - 08:55	Speech by Dr Shinsuke Murai (NCGM)
08:55 - 09:00	Speech by representative of the visiting delegation
09:00 - 10:30	**Hospital tour - Group 1**
09:00 - 09:45	Visiting Reception
	Visiting Outpatient Department (OPD)
	Visiting Laboratory
08:55 - 09:00	Visiting Neonatal Deparment
	Visiting Postnatal & Child Care Department
09:00 - 10:30	**Hospital tour - Group 2**
09:00 - 09:45	Visiting Neonatal Deparment
	Visiting Postnatal & Child Care Department
	Visiting Reception
08:55 - 09:00	Visiting Outpatient Department (OPD)
	Visiting Laboratory
10:30 - 11:00	**Feedback, Discussion and Closing**
11:00	**Lunch**

List of Participants

No.	Name	Affiliation
1	Duong Huy Luong	Quality Management Department, Medical Services Administration, Ministry of Health
2	Do Hong Phuong	UNICEF
3	Kyoko Takashima	JICA
4	Pham Van Man	Dien Bien Provincial General Hospital
5	Dang Thi Tu Loan	Dien Bien Provincial General Hospital
6	Pham Quang Phuoc	Son La Department of Health
7	Bui Thi Hoa	Son La Department of Health
8	Do Huu Minh	Son La Provincial Health Education and Communication Center
9	Nguyen Van Long	Mai Son District Hospital, Son La Province
10	Cam Thi Huong	Son La Provincial General Hospital
11	Lo Thi Bich Ngoc	Son La Provincial General Hospital
12	Bui Ngoc Minh	Son La Provincial General Hospital
13	Dao Viet Hung	Lai Chau Provincial General Hospital
14	Bui Duc Vuong	Lai Chau Provincial General Hospital
15	Nguyen Khanh Thuan	Lao Cai Provincial General Hospital
16	Nguyen Ngoc Minh	Lao Cai Provincial General Hospital
17	Tran Lan Anh	Yen Bai Department of Health Yen Bai Provincial General Hospital
18	Nguyen Trung Hieu	Yen Bai Provincial General Hospital
19	Do Dinh Van	Hoa Binh Provincial General Hospital
20	Le Tien Thanh	Hoa Binh Provincial General Hospital
21	Dang Hoang Nga	Thai Nguyen Central General Hospital
22	Nguyen Thi Huong Giang	Bach Mai Hospital
23	Nguyen Thi Thu Ha	Bach Mai Hospital
24	Nguyen Thi Huong Lien	Ha Dong General Hospital
25	Nguyen Xuan Thiem	Ha Dong General Hospital
26	Nguyen Thi Xuan	Me Linh General Hospital
27	Pham Huu Thuong	Hanoi Lung Hospital
28	Vu Van Du	National Hospital for Obstetrics and Gynecology
29	Nong Minh Hoang	National Hospital for Obstetrics and Gynecology
30	Uong Thanh Tung	Saint Paul Hospital
31	Tran Thi Quynh Anh	Thai Binh Provincial General Hospital
32	Pham Thi Phuong Hanh	Ninh Binh Provincial General Hospital

No.	Name	Affiliation
33	Le Hong Trung	Vinh Phuc Provincial General Hospital
34	To Quang Hung	Vinh Phuc Provincial General Hospital
35	Hoang Song Hao	Ha Tinh Provincial General Hospital
36	Hoang Quoc Anh	Ha Tinh Provincial General Hospital
37	Nguyen Trong Tam	Vinh International Hospital
38	Phan Hai Thanh	Hue Central Hospital
39	Dang Duy Quang	Hue Central Hospital
40	Pham Nguyen Da Thao	Hue Central Hospital
41	Tran Le Bao Tram	Hue Central Hospital
42	Tran Thi Thuy Phuong	Hue Central Hospital
43	Ngo Viet Loc	Hue Medical and Pharmaceutical University Hospital
44	Le Viet Nho	Quang Nam Central General Hospital
45	Tran Quang Dat	Quang Nam Central General Hospital
46	Tran Hoai Bao	Quang Nam Central General Hospital
47	Phan Thi Thu Thuy	Quang Nam Central General Hospital
48	Nguyen Thi Thao	Quang Nam Central General Hospital
49	Nguyen Huu Xuan Truong	Da Nang Department of Health
50	Tran Dinh Vinh	Da Nang Hospital for Women and Children
51	Nguyen Son	Da Nang Hospital for Women and Children
52	Le Thi Hoa	Da Nang Hospital for Women and Children
53	Nguyen Thanh Van	Da Nang Hospital for Women and Children
54	Huynh Thi Bich Ngoc	Da Nang Hospital for Women and Children
55	Thai Thi Thanh Thuy	Da Nang Hospital for Women and Children
56	Nguyen Tran Anh Thu	Da Nang Hospital for Women and Children
57	Le Thi Nhu Quynh	Da Nang Hospital for Women and Children
58	Nguyen Thi Thanh Hong	Da Nang Hospital for Women and Children
59	Tran Dinh Trung	Da Nang Hospital for Women and Children
60	Hua Thi Le Chi	Da Nang Hospital for Women and Children
61	Nguyen Bang Dinh	Da Nang Hospital
62	Le Gia Loc	Da Nang Hospital
63	Duong Thi Vy Yen	Da Nang Eye Hospital
64	Phan Huu Hao	Da Nang Hospital for Mental Health
65	Doan Van Hung	Da Nang Dermato-Venereology Hospital
66	Nguyen Duy Khanh	Da Nang Traditional Medicine Hospital
67	Ho Quy Phuong	Da Nang Traditional Medicine Hospital
68	Le Dinh Cu	Da Nang Rehabilitation Hospital
69	Dang Thi Phuong Dung	Da Nang Hospital for Tuberculosis and Lung Diseases
70	Tran Thi Anh Nguyet	Lien Chieu District Hospital, Da Nang

No.	Name	Affiliation
71	Ngo Thi Cam Vien	Lien Chieu District Hospital, Da Nang
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73	Tran Hung Minh	Thanh Khe District Hospital, Da Nang
74	Pham Thi Thu Hoa	Hai Chau District Hospital, Da Nang
75	Kim Thi Thuan	Hai Chau District Hospital, Da Nang
76	Tran Thi Phi Nga	Son Tra District Hospital, Da Nang
77	Phan Xuan Thanh	Ngu Hanh Son District Hospital, Da Nang
78	Nguyen T. Don	Cam Le District Hospital, Da Nang
79	Dang Thi Cong	Hoa Vang District Hospital, Da Nang
80	Ha Vi Khanh	Hoa Vang District Hospital, Da Nang
81	Tran Thi Hang	Family Hospital Da Nang
82	Su Thi Ngan	Hoan My Hospital Da Nang
83	Pham Thi Hong Nhi	Binh Dan Hospital, Da Nang
84	Le Thi Hoang Van	Da Nang Oncology Hospital
85	Nguyen Thi Ha	Da Nang Oncology Hospital
86	Nguyen The Toan	Quy Hoa National Leprosy - Dermatology Hospital
87	Pham Viet Thai	Ninh Thuan Provincial General Hospital
88	Ton Thanh Tra	Cho Ray Hospital
89	Dang Hoang Vu	Cho Ray Hospital
90	Tran Quang Hien	An Giang Hospital of Obstetrics, Gynecology and Pediatrics
91	Huynh My Thu	Thu Duc District Hospital, Ho Chi Minh City
92	Luong Hoang Liem	Thu Duc District Hospital, Ho Chi Minh City
93	Luong Ngoc Minh Thanh	Thu Duc District Hospital, Ho Chi Minh City
94	Tran Nguyen Nhu Anh	Tu Du Hospital
95	Phan Thi Hang	Hung Vuong Hospital
96	Tran Thi Thanh Thuy	Hung Vuong Hospital
97	Le Thi Kim Dai	Can Tho Central General Hospital
98	Shinsuke Murai	NCGM, Japan
99	Jun Moriyama	NCGM, Japan
100	Koji Wada	NCGM, Japan
101	Yuni Otsuka	NCGM, Japan
102	Nguyen Hong Anh	MCC Hanoi
103	Le Thi Thu Phong	MCC Hanoi
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Volume 2

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