

Volume 1
# Table of Contents

Guideline for Citation .............................................................. 02  
Foreword .................................................................................... 03  
Abbreviation .............................................................................. 04  

**Session 1** Learning Culture in Hospital .............................................................. 05  
Shifting from Punishment Culture to Learning Culture to Improve Patient Safety  05  

**Session 2** Establishing Hospital Incident Reporting System ................................. 10  
2-1 Establishment of Medical Incident Management System in Bach Mai Hospital  10  
2-2 Developing Incident Reporting System in Ha Nam Provincial General Hospital 13  

**Session 3** Improving Compliance to Timing Standard ......................................... 17  
Improving Compliance to Standard Emergency Response Time from 55% to 85% in December 2015  17  

**A Topic from Japan** ..................................................................... 22  
Eight Core Values in Quality Management in Japan  22  

**Session 4** Improving Service Quality in OPD .................................................. 26  
Plan to Improve Management and Medical Safety in Prescription for Outpatients  26  

**Session 5** 5S ................................................................................. 31  
5-1 5S Implementation in Two Departments in Ninh Binh Provincial General Hospital  
(Nephro-urological Surgery and Endocrinology Departments)  31  
5-2 5S Implementation in Ha Dong General Hospital  35  
5-3 Project for 5S Implementation in Thai Binh Provincial General Hospital  42  
5-4 Who is customer? 5S  46  

**Session 6** Improving Quality in Clinical Departments ............................................. 48  
6-1 Reducing Ventilator Associated Pneumonia by 5% and Pressure Ulcer by 10% in ICU within 3 Months  48  
6-2 Increasing the Rate of Proper Use of Prophylactic Antibiotics in Surgery from 65% to 75% after One PDCA Cycle  51  

**Session 7** Updates from the Ministry of Health ..................................................... 59  
Applying Hospital Quality Standards to Improve Hospital Quality and Patient Care  59  

Forum Outline ............................................................................. 63  
Program ....................................................................................... 64  
Steering Committee .................................................................... 66  
List of Participants ....................................................................... 67
Guideline for Citation

How to cite this book:

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

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

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

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

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

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

# Abbreviation

| AMS | Antimicrobial stewardship               |
| CQI | Continuous quality improvement         |
| DI  | Diagnostic imaging                      |
| DOH | Department of Health                    |
| EBM | Evidence-based medicine                 |
| ESBL| Extended-spectrum beta-lactamase        |
| FE  | Functional examination                   |
| GPD | General planning department             |
| HQS | Hospital Quality Standards              |
| ICU | Intensive care unit                     |
| IRS | Incident reporting system               |
| KYT | Hazard prediction training (Kiken yochi training) |
| MOH | Ministry of Health                      |
| NAP | National Action Program                 |
| OPD | Outpatient department                   |
| PDCA| Plan – Do – Check - Act                 |
| PS  | Patient safety                          |
| QI  | Quality improvement                     |
| QM  | Quality management                      |
| QMD | Quality management department           |
| RCA | Root cause analysis                     |
| SOP | Standard operational procedure          |
| SSI | Surgical site infection                 |
| VAP | Ventilator associated pneumonia         |
Session 1

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

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Quality Management Department, Quang Nam Central General Hospital

1. Reason for choosing the topic

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

2. Implementation plan

- Studying the results of incident collection, handling and response of the voluntary incident reporting system (IRS) as well as the alternate incident detection system of the Quality Management Department (QMD).
- Surveying staff perception on safety culture in the hospital in two rounds: the first in April 2015 and the second in October 2015.

3-a. Current state

- Results of the voluntary IRS’s incident collection, handling and response as well as QMD’s alternate incident detection system show that:
  After establishing the IRS, the number of medical incident reports increases with an average of 7.5 reports per month, but the data is not stable: the number of reports gradually increases from April to the peak in August, then decreases gradually, the difference between months can reach more than 200% (Figure 1):

  ![Graph showing incident reports]

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

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

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

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

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

3-b. Objectives

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

4. **Analysis of the affecting factors**

Causes of punishment culture come from 2 groups:

4.1. **Objective causes: Difficult to change**

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

**Legal system and policy:**
- Incomplete legal system in terms of protection of people who report incidents.
- Policy contradiction is an obstacle for institutions to change their culture through staff training, especially health insurance payment policy.
- There are no mechanisms for protection and safety assurance for reporters when reporting errors.
- There are no independent agencies responsible for monitoring medical incidents.

4.2. **Subjective causes: Can be changed**

The hospital has not developed a safe environment for reporting or displaying medical incidents:
- The top leaders of hospital and departments are not yet committed and don’t regularly confirm non-punishment policy for incident reporting.
- Hospital policies are not consistent and do not show priority for PS.
- Healthcare workers, especially doctors, are not believing in the organization and effectiveness of IRS.

**QMD and in-charge staff lack experience in collecting and analyzing medical incidents and giving feedback to hospital staff properly:**
- In-charge staff and PS network haven’t been trained and organized for proper operation.
- Procedures for receiving, collecting and analyzing incidents and giving feedback are not complete yet.

**Actual state of PS training for hospital leaders and staff:**
- The number of leaders and doctors who were trained on PS is small: 8/11 members of QM Council, which is 73%; 17/38 doctors who are chiefs or vice chiefs of departments, 45%; 4/54 other doctors, 7%; 19/19 head nurses, 100%; 35/35 members of QM network, 100%.
- Training and communication activities are not maintained regularly and effectively.
**1. REASON FOR CHOOSING THE TOPIC**

- **Safety culture**
- **Learning culture**
- **Punishment culture**

**2. ACTION PLAN**

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

**3. Actual state of the hospital**

1. Voluntary IRS and alternate incident detection system

   - Monthly average number of incident reports: 7.5 reports
   - Only some incidents at level 3b or above were reported.
   - Some incidents at level 3b were root cause analyzed, providing report and feedback to the system.
3. Actual state of the hospital

2. Results of safety culture surveys in April and October 2015

Regarding the question “In the hospital, medical incidents are handled properly”:

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

Objectives

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

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

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

Causes

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

Individual

- Conservative
- Do not accept change

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

Society’s viewpoint

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

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

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

Step 1: Making plan

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

Step 2. Training and communication

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

3. Compliance and implementation

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

4. Evaluation of implementation

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

“To err is human, to cover up is unforgivable, and to fail to learn is inexcusable.”

Liam Donaldson
Session 2-1

Establishment of Medical Incident Management System in Bach Mai Hospital

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

1. Reason for choosing the topic
   In regard to PS, recording medical incidents will help hospitals to analyze roots causes and generate preventive measures.

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

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

3-b. Objective
   To establish a medical incident management system in Bach Mai Hospital.

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

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

Introduction of Bach Mai Hospital

A special level, complete general hospital
There are 2,300 staff and 1,900 planned beds.
There are 3 institutes, 8 centers, 23 clinical departments and 6 para-clinical departments.
There are 4,000 inpatients and 4,500 outpatients everyday.
9 tasks:
1. Providing last level examination and treatment
2. Conducting scientific research
3. Verifying health status
4. Training
5. Directing healthcare activities to low levels
6. International cooperation
7. Epidemic and disaster prevention
8. Hospital quality management
9. Hospital management
Organization of hospital QM system

QM COUNCIL

QMD (Permanent member)

PS COMMITTEE

QUALITY MEASUREMENT COMMITTEE

QI COMMITTEE

QM NETWORK

QM ACTIVITIES

ISO 9001:2008

ISO 15189

ISO 17025

Reason for choosing the activity

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

Action plan

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

Actual situation

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

Objective

TO ESTABLISH A MEDICAL INCIDENT MANAGEMENT SYSTEM IN BACH MAI HOSPITAL

Implementation plan

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

Heinrich PRINCIPLE

1 serious accident

30 small accidents

300 near misses

Important

Reason for choosing the activity

In regard to PS, recording medical incidents will help hospitals to analyze root causes and generate preventive measures.
**DEVELOPMENT OF REGULATION ON INCIDENT MANAGEMENT**

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

**IMPLEMENTATION PLAN**

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

**DIFFICULTIES AND CHALLENGES**

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

**Thank you for your attention!**
Session 2-2

Developing Incident Reporting System in Ha Nam Provincial General Hospital

Phan Anh Phong
Vice Director, Ha Nam Provincial General Hospital

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

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

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

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

4. Cause analysis
- Not all hospital staff received trainings and guidance.
- Staff did not report voluntarily, did not understand the benefits of reporting and were afraid of punishment.
- The focal points of the system did not work actively.
- Personnel changes in the directing board.

5. Proposed solutions and actual implementation
- The directing board and core staff were provided information. However, only few people have changed their perceptions.
- IRS and procedure were developed. However, it does not function as well as expected.

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

7. Solutions to maintain and develop the system
- Make the director pay more attention.
- Assign an in-charge staff.
- Encourage focal people to work more actively.
- Actively provide information and trainings and show effectiveness.

8. Lessons learned
- Establishing an IRS is not difficult.
- Making the system work effectively and bring real benefits is not simple.
Developing incident reporting system in Ha Nam Provincial General Hospital

Dr. Phan Anh Phong, MD., MSc.
Vice Director, Ha Nam Provincial General Hospital

REASONS FOR CHOOSING THE TOPIC

“To err is human.”

Previous state in Ha Nam Provincial General Hospital:
- Many medical incidents and errors used to occur and repeat in the hospital.
- Some incidents were hidden.
- Individuals who committed mistakes had to suffer all consequences.

Changes of perception after the training in NCGM
- IRS helps hospitals to control medical incidents: level, quantity, proportion, frequency, causes... thereby warnings and solutions will be provided to minimize potential incidents.

MEETING FOR PLAN IMPLEMENTATION

INFORMATION MANAGEMENT BOOK

INCIDENT ANALYSIS

INCIDENT REPORTING FORM

PS NETWORK

Each department: 1-3 persons
Chief of department, head nurse and some dynamic, enthusiastic members.
Including all departments
CURRENT STATE

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

CAUSE ANALYSIS

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

SOLUTIONS TO MAINTAIN AND DEVELOP THE SYSTEM

Make the director pay more attention.
Assign an in-charge staff.
Encourage focal people to work more actively
Actively provide information and trainings and show effectiveness.
- Protect reporters
- Analyze root causes of reported incidents and generate warnings so that people see the benefits of reporting.

OBJECTIVES

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

LESSONS LEARNT

• Establishing an IRS is not difficult.
• Making the system work effectively and bring real benefits is not simple.
Thank you very much
Session 3

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

Dr. Pham Viet Thai

Quality Management Department, Ninh Thuan Provincial General Hospital

1. Reason for choosing the topic

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

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

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

2. Implementation plan

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

Staff were guided to follow the timing regulation.

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

3-a. Current state

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

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

3-b. Objective

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

4. Cause analysis

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

Some overworking positions due to lack of manpower.

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

Staff's working spirit was not high enough.

5. Action plan

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

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

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

OVERVIEW OF NINH THUAN PROVINCIAL GENERAL HOSPITAL
- 2nd level hospital
  - Planned beds: 650
  - Actual beds: 868
- 32 departments:
  - 8 functional departments
  - 7 para-clinical departments
  - 17 clinical departments
- Staff: 756

- QMD was established in December 2013.
- Currently there are 06 staff:
  + 01 doctor
  + 01 nurse
  + 02 secondary pharmacists
  + 01 bachelor in hospital management
  + 01 bachelor in information system management

- Analyzing root causes of non-compliance.

CONTINUOUS IMPROVEMENT

Goal: improving patient satisfaction in Pediatrics Department

Objective by 2016

15% unsatisfied patients

CONTINUOUS IMPROVEMENT

Goal: staff’s compliance to handwashing in 2016

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

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

DID YOUR HOSPITAL ISSUE REGULATION ON EMERGENCY RESPONSE TIME?

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

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

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

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

2. Implementation plan

- In 2014, the hospital issued regulation on emergency response time for each step in the emergency procedure [1].
- Staff were guided to follow the timing regulation.
- Checking, monitoring and evaluation of compliance to the timing regulation are conducted monthly and unannounced.
Time standards in the emergency procedure
- Time for doctor to examine and initially handle since receiving patient, calculated based on the time in medical record, is maximum 20 minutes for level 4.
- Time for laboratory tests, calculated based on the time in the result paper attached with the medical record:
  + Time for nurse to collect and send specimen since doctor gives indication is maximum 50 minutes for level 4;
  + Time for test turnaround since specimen is received is maximum 180 minutes for level 4;
  + Time for nurse to check test results and inform doctor to write down abnormal results that affect diagnosis, is maximum 30 minutes for level 4;
  + Time for doctor to intervene after receiving test results is maximum 30 minutes without operation, 90 minutes with operation for level 4.

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

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

3a. Current state
Among the results:
- For emergency patients in severe state that need quick emergency response (emergency levels 1, 2): incompliance rate regarding this group was very high (89.2%).
- Internal medicine departments (ICU, 02 internal medicine departments and Pediatrics Department) had incompliance rates of 67%.
- Average time for FE turnaround: 418.3 minutes; DI turnaround: 327.4 minutes; which were much longer than in the regulation.
### 4. Causes of Incompliance to Standard Emergency Response Time

- Nurses working in internal medicine departments did not know how to arrange their work.
- The regulations on standard emergency response time were not comprehended well.
- Staff’s working spirit was not high enough.
- The level of emergency was not specified so para-clinical staff did not prioritize the work.
- Staff’s working spirit was not high enough.

### 5. Action Plan

<table>
<thead>
<tr>
<th>No.</th>
<th>Activities</th>
<th>Responsibility</th>
<th>Time</th>
<th>Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adjusting the regulation on time standard for each step in the emergency procedure</td>
<td>Scientific Council</td>
<td>2/2015</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Restraining on the hospital’s regulation on standard emergency response time</td>
<td>Dr. Thai</td>
<td>02/2016</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Training on specimen collection techniques for nurses</td>
<td>Nursing Department, Laboratory</td>
<td>2015</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Training on 5S knowledge for staff</td>
<td>Committee</td>
<td>01/2015</td>
<td></td>
</tr>
</tbody>
</table>

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### Target of Study

- Inpatients in Ninh Thuan Provincial General Hospital from March to October 2016.

### Study Method

- Descriptive, cross sectional study with analysis

### Sample Size

- Calculated by the formula:
  
  \[ n = \frac{Z^2 \times (1-p)}{d^2} \]

- Of which: \( p = 0.05 \): confidence interval 95%, \( Z(1-0.05) = 1.96 \)
- \( d = 0.04 \): acceptable error (desired precision) is 4%
- \( p = 0.85 \): compliance rate to standard timing

- From the above formula, \( n \# 300 \)

### References

3. Archive of minutes/reports of technical reviews and medical record reviews in Ninh Thuan Provincial General Hospital in 2014.
4. Hospital Quality Standards (Issued with Decision no. 4858/QD-BYT dated 03 December 2013 by the Minister of Health).

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**THANK YOU FOR YOUR ATTENTION**
A Topic from Japan

Eight Core Values in Quality Management in Japan

Shinsuke Murai
Bureau of International Health Cooperation, NCGM, Japan

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

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

Most of these eight core values are not new to Vietnam. Core values exist in our culture and daily life.
Core value 1
Quality first

We work for Quality
Money comes after that

Core value 2
Customer oriented

“Customer is God”

Saying in Japanese industry

To think of “Quality” is to think of “Objectives”
(Naruo UEHARA, 1993)

Definitions of Quality

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

Are you customer?
Do you know what customers want?
Core value 3:

**Vital few**

- Activity
- Activity
- Activity
- Activity

Prioritized activity

Core value 4:

The next process is still **customer**

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Pharmacist</th>
<th>Nurse</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Error in indication</td>
<td>Wrong drug</td>
<td>Wrong drug</td>
<td>Patient takes wrong drug</td>
</tr>
<tr>
<td>Error in care of medical equipment</td>
<td>Examination</td>
<td>Doctor doesn’t work</td>
<td>Patient is not examined</td>
</tr>
</tbody>
</table>

Core value 5:

Quality must be built in the process

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

Quality is built in process

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

- Input
- Process (way of work)
- Output
- Bad result

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

Hosotani, K. 1989

Wrong design (way of work) will cause bad result

“*The Design of Everyday Things*” (2002)
Asakusa temple has lanterns
Asakusa temple is beautiful

Core value 6:
Management by facts

KKD (勘、経験、度胸)
Kan Keiken Dokyo
Intuition Experience Braveness
Talk to facts

Core value 7:
Errors are treasure

Problems

Improvement opportunities

Core value 8:
Respect humanity

Eight core values in quality management in Japan

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

Core values are easy to talk about but difficult to implement

But not impossible,

As we see efforts in this forum
Session 4

Plan to Improve Management and Medical Safety in Prescription for Outpatients

Tran Quang Hien
An Giang Hospital of Obstetrics, Gynecology and Pediatrics

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

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

3. Identifying causes of errors in prescription

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

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

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

4.4. Environment:
- Implementing 5S

4.5. Measurement:
- Developing reporting and statistics system

4.6. Policy:
- Developing pharmaceutical manual
- Issuing plan
5.  Division of work

<table>
<thead>
<tr>
<th>5.  Division of work</th>
<th>11.  Achieved results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TÍNH ĐỒ THỰC HIỆN KHÓA</strong></td>
<td><strong>Compliance rates to treatment protocols</strong></td>
</tr>
<tr>
<td><strong>Thành phần</strong></td>
<td><strong>Month</strong></td>
</tr>
<tr>
<td><strong>Phúc vụ</strong></td>
<td><strong>July</strong></td>
</tr>
<tr>
<td>A</td>
<td>11.1</td>
</tr>
<tr>
<td>B</td>
<td>11.6</td>
</tr>
<tr>
<td>C</td>
<td>11.11</td>
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<tr>
<td>D</td>
<td>11.16</td>
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<td>E</td>
<td>11.21</td>
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<td>F</td>
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<td>G</td>
<td>11.31</td>
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<td>H</td>
<td>11.36</td>
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<tr>
<td>I</td>
<td>11.41</td>
</tr>
<tr>
<td>J</td>
<td>11.46</td>
</tr>
<tr>
<td>K</td>
<td>11.51</td>
</tr>
</tbody>
</table>

6.  Implementation

1.  Issuing policy
   - The directing board issued implementation plan;
   - The director issued documents on updating and developing new treatment protocols based on the hospital’s disease pattern, MOH’s documents and evidence based medicine (EBM);

2.  Applying information technology
   - Hsoft, which can check drug interactions for OPD, has been employed

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

4.  Developing reporting system

5.  Training, checking, monitoring

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

7.  Achieved results

**Plan to improve management and medical safety in dispensing drugs to patients in outpatient department**

**PRESENTATION**

**PLAN TO IMPROVE MANAGEMENT AND MEDICAL SAFETY IN DISPENSING DRUGS TO PATIENTS IN OUTPATIENT DEPARTMENT**

Dr. Tran Quang Hien, MD, PhD,
Director of An Giang Hospital of Obstetrics,
Gynecology and Pediatrics

**Achieved results**

Compliance rates to treatment protocols

<table>
<thead>
<tr>
<th>Month</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total OPD</td>
<td>40,173</td>
<td>36,658</td>
<td>36,789</td>
<td>41,031</td>
<td>38,526</td>
</tr>
<tr>
<td>Outpatient turns in internal medicine</td>
<td>22,810</td>
<td>20,931</td>
<td>20,460</td>
<td>22,004</td>
<td>20,864</td>
</tr>
</tbody>
</table>

**Compliance rates to treatment protocols (%)**

<table>
<thead>
<tr>
<th>Month</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
</tr>
</thead>
<tbody>
<tr>
<td>57</td>
<td>80</td>
<td>90</td>
<td>73</td>
<td>83</td>
<td></td>
</tr>
</tbody>
</table>

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

**Results:**

+ The number of prescriptions with mistakes reduced 25% on average.
+ Outpatient prescription indicator: decreased from 6.2 to 2.75.
+ Drugs cost reduced from 72% (2013) to 62% (2015)
II. OBJECTIVE

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

III. CAUSE IDENTIFICATION

IV. SOLUTIONS

1. Personnel:
   - Training and updating treatment protocols
   - Reinforcing prescription check by pharmacists (double check)
2. Machine:
   - Employing a prescription software that can check drug interactions.

IV. SOLUTIONS (2)

3. Procedure:
   - Issuing standard operation procedure (SOP)
   - SOP for prescription check and monitoring
4. Environment:
   - Implementing 5S

IV. SOLUTIONS (3)

5. Measurement:
   - Developing reporting and statistics system
6. Policy:
   - Developing pharmaceutical manual
   - Issuing plan

V. WORK DIVISION AND PROGRESS

VI. Implementation

A. Issuing policy

B. Developing protocols and SOPs
Session 4 | Improving Service Quality in OPD

C. Prescription software

D. Implementing 5S

E. Developing reporting system

F. Training and checking

G. ABC/VEN analysis
H. Results

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

Results:
+ The number of prescriptions with mistakes reduced 25% on average.
+ Outpatient prescription indicator: decreased from 6.2 to 2.75.
+ Drugs cost reduced from 72% (2013) to 62% (2015).
1. Reason for choosing the topic

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

2. State before implementation

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

- 5S evaluation scores (using the checklist developed by the QMD):
  - Nephro-Urological Surgery Department: 54/100 points
  - Endocrinology Department: 48/100 points

3. Objective

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

4. 5S implementation plan

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

From January to March 2016

- Week 1: Guiding the two departments to implement 5S
- Week 2 to week 10: The task force evaluates using the 5S checklist twice a week and gives advice to 5S implementation.
- Week 11 and 12: Summarizing the results of 5S implementation in the two departments, reporting to the Steering Committee to generate lessons learnt and direction for expansion in the entire hospital.
**Reasons for choosing the topic**

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

**Actual state before implementation**

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

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

**5S implementation plan**

From January to March 2016
- Week 1: Guiding the two departments to implement 5S
- Week 2 to week 10: The task force evaluates using the 5S checklist twice a week and gives advice to 5S implementation.
- Week 11 and 12: Summarizing the results of 5S implementation in the two departments, reporting to the Steering Committee to generate lessons learnt and direction for expansion in the entire hospital.
**5S guidelines**

**Evaluation of actual state and images before implementation**

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

**5S evaluation checklist**

**Difficulties and challenges in implementing 5S program**

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

**Proposed solutions**

- Increasing 5S knowledge :
  - Conducting training courses
  - Giving direct instructions in departments
  - Providing 5S materials and pictures
- Organizing contests of 5S implementation
- Strengthening 5S monitoring in departments
Session 5-2

5S Implementation in Ha Dong General Hospital

Nguyen Thi Huong Lien
Quality Management Department, Ha Dong General Hospital

1. Reason for choosing the topic

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

2. Implementation plan

Time: 12/2015

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

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

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

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

- Facility:
- Human resource:
- Working environment and condition:

Time: 01/2016

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

2.4. Implementing 5S: under current condition.

3. Objective

To develop a habit of applying 5S in the three laboratories.
Reasons for choosing the topic

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

Actual state before implementing 5S

- **As a satellite hospital of Bach Mai hospital: 12 departments were implementing ISO.**
- **The hospital was employing MOH’s HQS.**
  - Since October 2015: there have been remarkable changes.

Actual state of hospital

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

Actual state in three laboratories

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

To develop a habit of applying 5S in the three laboratories: Hematology-Blood Transfusion, Biochemistry, Microbiology Departments.

4. 5S implementation plan

- In December 2015:
  + Establishing a 5S Steering Committee including the director or a vice director as the chairman, chiefs of departments (3 laboratories) are members.
  + Responsibilities: developing and implementing a 5S program in the three laboratories.
  + Studying actual state of the three laboratories (with taking pictures):
    - Facility
    - Human resource
    - Working environment and condition

- January to March 2016:
  + Training on 5S and internal evaluation for the Steering Committee and all staff of the three laboratories.
  + Implement 5S in the 3 laboratories:
    - Under current condition: facility, equipment
    - Monitoring – evaluation:
    Internal evaluation group
  + Report
- May 2016:
  + Evaluation. Fixing problems.
  + Revise the procedure if it is not appropriate
  + Maintain 5S activities
Actual state of 5S implementation in 3 laboratories

Actual state of Hematology – Blood Transfusion Department
Actual state of Hematology – Blood Transfusion Department

Actual state of 5S in Hematology – Blood Transfusion Department

Actual state of Hematology – Blood Transfusion Department

Actual state of 5S in Hematology – Blood Transfusion Department

Actual state of Hematology – Blood Transfusion Department

Actual state of 5S in Hematology – Blood Transfusion Department

Actual state of Hematology – Blood Transfusion Department

Actual state of 5S in Hematology – Blood Transfusion Department

Actual state of Hematology – Blood Transfusion Department

Actual state of 5S in Hematology – Blood Transfusion Department
Actual state of 5S in Microbiology Department

Actual state of 5S in Biochemistry Department

Actual state of 5S in Microbiology Department

Actual state of 5S in Biochemistry Department

Actual state of 5S in Microbiology Department

THANK YOU!
1. **Reason for choosing the topic**
   To create a logical and comfortable working environment for hospital’s staff and to create a clean and safe environment for examination, caring and treatment for patients is very important to our hospital’s quality.

2. **Actual state before 5S implementation**
   - Departments were not clean and tidy.
   - Inappropriate arrangement of injection trolleys, drug cabinets, medical record store, etc.
   - Many unnecessary things in departments.
   - Toilets were dirty and untidy.

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

4. **Action plan**
   4.1. **Stage division:**
   - Stage 1: Pilot implementation
     - Select 5 departments for pilot implementation: General Surgery Department, Endocrinology Department, Oncology Department, Pharmacy Department and General Planning Department
     - Duration: 03 months, from 01 March 2016 to 30 May 2016.
   - Stage 2: Expansion
     - Departments voluntarily register to implement 5S
     - Duration: 03 months, from 01 June 2016 to 30 August 2016
   - Stage 3: Comprehensive implementation
   - Implementation in other departments
   - Duration: 03 months, from 01 September 2016 to 30 November 2016

4.2. **Activities:**

<table>
<thead>
<tr>
<th>STT</th>
<th>Time</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Week 1</td>
<td>- Evaluate actual state of departments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Take pictures</td>
</tr>
<tr>
<td>2</td>
<td>Week 2</td>
<td>- 5S training</td>
</tr>
<tr>
<td>3</td>
<td>Week 3</td>
<td>- Group work with departments staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Assign one person in charge of each area for 5S implementation</td>
</tr>
<tr>
<td>4</td>
<td>Week 4 to week 10</td>
<td>- Implement 5S in departments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Check, monitor and push implementation</td>
</tr>
<tr>
<td>5</td>
<td>Week 11 to week 12</td>
<td>- Evaluate implementation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Organize a workshop to present implementation results</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Generate lessons learnt, improve and make next implementation plans.</td>
</tr>
</tbody>
</table>
THAI BINH DEPARTMENT OF HEALTH
PROVINCIAL GENERAL HOSPITAL

PROJECT FOR
5S IMPLEMENTATION
IN THAI BINH PROVINCIAL GENERAL HOSPITAL IN 2016

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

THAI BINH PROVINCIAL GENERAL HOSPITAL
AND QM ACTIVITIES

- The hospital QM system is quite complete, including:
  * QM Council: 04 committees (of professional quality, infrastructure, manpower development and patient satisfaction)
  * QM: 06 staff (05 doctors, 01 nurse - 3 full-time staff and 03 part-time staff)
  * QM network: 42 members

THAI BINH PROVINCIAL GENERAL HOSPITAL
AND QM ACTIVITIES

1 st level hospital, the top level in Thai Binh province
+ Hospital’s structure: 41 departments (23 clinical departments, 05 para-clinical departments, 13 functional departments)
+ Human resource: 919 staff (231 doctors, 450 nurses, 75 technicians, 35 pharmacists)
  + 1,000 planned beds; 1,180 actual beds
  + Bed occupancy rate: 178% planned beds; 105% actual beds

THAI BINH PROVINCIAL GENERAL HOSPITAL
AND QM ACTIVITIES

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

THAI BINH PROVINCIAL GENERAL HOSPITAL
AND QM ACTIVITIES

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

THAI BINH PROVINCIAL GENERAL HOSPITAL
AND QM ACTIVITIES

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

THAI BINH PROVINCIAL GENERAL HOSPITAL
AND QM ACTIVITIES

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

THAI BINH PROVINCIAL GENERAL HOSPITAL
AND QM ACTIVITIES

5S PROJECT

1. REASONS FOR CHOOSING THE TOPIC
   - To create a clean, tidy and convenient working and treatment environment.
   - To reduce waste of time to concentrate on professional and patient care activities.
   - To reduce incidents related to illogical working environment
2. OBJECTIVE
* 100% departments in the hospital implement 5S by 30 November 2016.

3. ACTUAL STATE BEFORE 5S IMPLEMENTATION
* Departments were not clean and tidy.
* Inappropriate arrangement of injection trolleys, drug cabinets, medical record store, etc.
* Many unnecessary things in departments.
* Toilets were dirty and untidy.

4. ACTION PLAN
4.1. Preparation stage
* Duration: 01 month (March 2016)
* Contents:
  - Making plan
  - Establishing a QI group to implement 5S
  - Discussion
  - Developing documents
  - Preparing training materials…

4.2. Implementation stage
- Pilot implementation (03 months, from 01/4/2016 to 30/6/2016)
- Expansion (03 months, from 01/7/2016 to 30/9/2016)
- Comprehensive implementation (03 months, from 01/10/2016 to 30/12/2016)

Select 5 departments for pilot implementation: General Surgery Department, Endocrinology Department, Oncology Department, Pharmacy Department and GPD.

Departments voluntarily register to implement 5S Implementation in other departments.

5. Activities

<table>
<thead>
<tr>
<th>Week</th>
<th>Activity</th>
</tr>
</thead>
</table>
| 1    | Evaluate actual state of departments  
      | Take pictures                        |
| 2    | 5S training                         |
| 3    | Group work with departments staff  
      | Assign one person in charge of each area for 5S implementation |
| 4    | Implement 5S in departments  
      | Check, monitor and push implementation |
| 5    | Evaluate implementation  
      | Organize a workshop to present implementation results  
      | Generate lessons learnt, improve and make next implementation plan |

6. ADVANTAGES AND CHALLENGES
6.1. Advantages
- Hospital leaders always care and give direction to all QI activities, especially 5S implementation.
- Members of QM system and staff of QMD are very enthusiastic.
- QI activities in the hospital are receiving collaboration and agreement of healthcare workers.
- The hospital has a budget for 5S activities from the Norred project.
5S PROJECT
6. ADVANTAGES AND CHALLENGES
6.2. Advantages
- The issues raised for improvement in the project are urgent and necessary to improve in enhancement of examination, treatment, and patient care activities.
- Therefore, the Project is suitable, sustainable, and able to be extended to the whole hospital and to share experience for other hospitals.

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

Megumi Ikarashi
Bureau of International Health Cooperation, NCGM, Japan

Who is customer?
5S

What we should think about 5S in healthcare institutes?
First and foremost, enhancing professional efficiency and preventing medical incidents.
It is important to connect this enhancement with increasing patient satisfaction.
Furthermore, in order to do this, organizational management capacity is needed.

5S is easy to understand.
But...
5S is not easy to implement.

What is 5S?
- Sort: Sort distinguished items.
- Straighten: Clean and organize items and rooms neatly.
- Shine: Clean up regularly and ensure that the environment is free from garbage and dust.
- Standardize: Maintain cleanliness by strictly follow and insist 5S: Sort, Straighten, Shine.
- Sustain: Create habits of complying to developed regulations.

Who is customer?
Who is customer?

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

“Shitsuke” = Sustain
Session 6-1

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

Tran Quang Dat

ICU, Quality Management Department, Quang Nam Central General Hospital

1. Reasons for improvement activity

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

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

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


Establishing an improvement group

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

Analyzing root causes and proposing improvement solutions.

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

3. Objective

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

3_a. Current state

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

3_b. Targets for achievement

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

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

OBJECTIVES

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

ACTION PLAN

<table>
<thead>
<tr>
<th>No.</th>
<th>Activities</th>
<th>Time</th>
<th>In charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Establishing an improvement group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Surveying the rates of VAP per 1,000 days of mechanical ventilation and bedsore per 1,000 days of hospital stay</td>
<td>1 month</td>
<td>Improvement group</td>
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<tr>
<td>3</td>
<td>Exploring root causes and proposing improvement solutions</td>
<td>2 weeks</td>
<td>Improvement group and doctors in ICU</td>
</tr>
<tr>
<td>4</td>
<td>Training and implementing solutions</td>
<td>2 weeks</td>
<td>Dr. Dai and improvement group</td>
</tr>
<tr>
<td>5</td>
<td>Re-surveying the rates of VAP and bedsore</td>
<td>After 1, 2, 3 months of interventions</td>
<td>Improvement group</td>
</tr>
</tbody>
</table>
CAUSE ANALYSIS FOR BEDSORE

Causes are related to nursing care.
• Nurses did not follow properly procedures for bedsore prevention.
• Lack of bedsore prevention devices.
• Patient’s nutrition status was not assessed fully for intervention.

PROPOSED IMPROVEMENT MEASURES

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

CAUSE ANALYSIS FOR PNEUMONIA

Employing fishbone diagram and 5 WHY, we identified some following causes:
• Nurses did not follow the procedure for taking care of patients with mechanical ventilation.
• Lack of devices such as: tracheal tube, bag mask, cuffed tracheal tube…
• Cleaners: no procedure for treatment of ventilator after use
• Environment of ICU was not treated regularly.

POST-INTERVENTION EVALUATION

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

PROPOSED IMPROVEMENT MEASURES

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

CHALLENGES

• The number of patients with mechanical ventilation per month is small → data might be inaccurate.
• Buying more equipment → more costs.
Antimicrobial Stewardship Program Helps Increase the Rate of Proper Use of Prophylactic Antibiotics in Surgery from 65% to 75% after One PDCA Cycle

Ton Thanh Tra
Quality Management Department, Cho Ray Hospital

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

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

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

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

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

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

5. Next plan
- Strengthening infection control
- Studying SSI rates, comparing compliant group and non-compliant group
- Strengthening monitoring activities
- Organizing meetings to review antibiotics indication in medical records
- Setting objective for a new PDCA cycle (80%) in the
next 2 months and the rate of improper use of antibiotics after surgery reduces from 80% to 50%.

6. Conclusion

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

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

RESISTANCE SITUATION OF K.PNEUMONIAE

- Most of antibiotics are resisted by > 50%
- Amikacin, Netimycin, Carbapenem: 35%

INTRODUCTION OF AMS PROGRAM

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

NUMBERS OF SPECIMENS

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5 PATHOGENIC BACTERIA

AMS PROGRAM

- Guideline for antibiotic use was developed in 2010 and updated in 2013.
- Trainings were conducted in 2013-2014
- Monitoring from June 2014 to present.
- Pilot implementation in 6 clinical departments:
  Respiratory Internal Medicine Department, ICU, Tropical Diseases Department, Urology Surgery Department, Gastroenterology Surgery Department and Hepatology Surgery Department.
THE RATES OF CHOOSING THE FIRST ANTIBIOTICS FOLLOWING THE HOSPITAL’S GUIDELINE

THE RATES OF SENDING SPECIMEN FOR CULTURE BEFORE INDICATING ANTIBIOTICS

PRE-OPERATIVE ANTIBIOTICS USE

RATE OF PROPER USE

PROPHYLACTIC ANTIBIOTICS

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

SSC RISK STRATIFICATION

- Clean: 49.2%
- Clean-Contaminated: 16.9%
- Contaminated: 2.3%
- Dirty: 0.3%

One Step "Get it right the first time"
Progress This Way
Slow

Look behind to see how far we’ve come...
**OBJECTIVE**

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

**PRE-OPERATIVE PROPHYLACTIC ANTIBIOTICS USE**

<table>
<thead>
<tr>
<th>Number of medical record</th>
<th>Clean</th>
<th>Clean-contaminated</th>
</tr>
</thead>
<tbody>
<tr>
<td>4B1</td>
<td>134</td>
<td>37</td>
</tr>
<tr>
<td>4B3</td>
<td>44</td>
<td>24</td>
</tr>
<tr>
<td>5B1</td>
<td>120</td>
<td>59</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>298</strong></td>
<td><strong>120</strong></td>
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</table>

**RESULTS**

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

**INTERVENTIONS**

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

- Organizing a group to monitor antibiotics prescription in daily operation approval.
- Evaluating and reporting monitoring results at the end of each month.
Practices in Hospital Quality Management and Patient Safety in Vietnam: Challenges and Achievements  Volume 1

POST-OPERATIVE ANTIBIOTICS USE

Following hospital’s guideline

<table>
<thead>
<tr>
<th>Duration of Antibiotics Use</th>
<th>Cases using Antibiotics after surgery</th>
<th>Antibiotics combination</th>
<th>Diagnosed with infection</th>
<th>Question of antibiotics use after surgery (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>150</td>
<td>91%</td>
<td>0%</td>
<td>5%</td>
<td>78%</td>
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<td>27</td>
<td>80%</td>
<td>40%</td>
<td>40%</td>
<td>75%</td>
</tr>
<tr>
<td>6</td>
<td>40%</td>
<td>60%</td>
<td>60%</td>
<td>74%</td>
</tr>
<tr>
<td>5</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>73%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

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

POST-OPERATIVE ANTIBIOTICS USE

Antibiotics were indicated after surgery without diagnosis of infection:
- 150 cases (80%) continued to use antibiotics after surgery
- 27 cases combined 2 kinds of antibiotics

WHY SURGEONS DID NOT COMPLY?
- Too busy to concern.
- Longtime habit of using antibiotics after surgery is difficult to change
- Not fully aware of antimicrobial resistance situation

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

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

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

IT APPLICATION
Conclusions

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

APPLICATION ON SMARTPHONE

THANK YOU AND ENJOY YOUR TIME
HAPPY NEW YEAR 2016

WELCOME TO VIETNAM FORUM
ON QUALITY MANAGEMENT
AND PATIENT SAFETY 2016

Dr. Ton Thanh Tra, MD., MSc.
Quality Management Department
Cho Ray Hospital
Session 7

Applying Hospital Quality Standards to Improve Hospital Quality and Patient Care

Duong Huy Luong

Vice chief of QMD, Medical Services Administration, MOH

HOSPITAL QUALITY MANAGEMENT APPLYING HOSPITAL QUALITY STANDARDS TO IMPROVE HOSPITAL QUALITY AND PATIENT CARE

HOSPITAL QUALITY FORUM
NCGM – BACH MAI HOSPITAL

Dr. Duong Huy Luong, MD., PhD.
Vice chief of QMD, Medical Services Administration, MOH

NEW VIEWPOINTS

“IMPROVING MEDICAL SERVICES QUALITY WITH PATIENT CENTEREDNESS FOR PATIENTS’ SAFETY AND SATISFACTION”

A SERIES OF “REFORMS” HAVE BEEN BEING IMPLEMENTED

- Reform in management: establishing QM systems in all hospitals (Circular 01/2015)
- Reform in knowledge: learning from advanced countries
- Reform in viewpoint: patients are put at the center of nursing care and treatment
- Reform in way of work: improving examination procedures, reducing administrative procedures (Decision 1313, Directive 05)
- Reform in method: replacing annual hospital check by hospital quality evaluation following the new 83 criteria (Decision 4858)
- 2015: Reforms in service manner, uniform...

POLICIES AND TOOLS ISSUED IN 2015 TO ENHANCE HEALTHCARE SERVICES QUALITY

On announcement and guidance for submitting applications for outstanding hospitals (to encourage hospitals to improve their quality)

- TITLE OF OUTSTANDING QUALITY HOSPITAL
- Improved examination procedures
- Patient care
- Active in reducing workload and keeping commitment of no bed sharings among patients
- Infection controlled, clean and green
- Developed human resource
- IT application
- Developed techniques and professional qualifications
- Practising clinical nutrition
- Improved laboratory quality
- Rational drug use
- Active in scientific research
- Enhanced PS
- Active in QI
- Receiving and handling patient’s feedback effectively
**TENTATIVE ACTIVITIES**

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

1. Develop, issue and monitor implementation of legal documents related to healthcare services quality,
   - Circular guiding management of medical incidents
   - Hospital quality standards (HQS)
   - Medical services quality standards for communal health centers

1.2. Develop policies to encourage improve quality of healthcare institutions and healthcare practitioners
   - Promote and facilitate the establishment of a healthcare accreditation organization
   - Update and adjust regulations on granting practising certificates and assessing professional qualifications and ethics.

**NATIONAL ACTION PROGRAM (NAP) TO IMPROVE QM CAPACITY TILL 2025**

(issued with Decision number 4276/QD-BYT dated 4 October 2015 by the Minister of Health)

**NAP’S SPECIFIC OBJECTIVES**

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

**TENTATIVE ACTIVITIES**

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

2.1. Develop HQS and quality standards for other healthcare institutions.
2.2. Develop competency standards for practitioners: General doctors, specialized doctors, technicians, midwives.
2.3. Develop some specialized quality standard sets for: nursing care, infection control, reproductive health, etc.

2.4. Develop, conduct a pilot, evaluate and release the HQS.
2.5. Develop the lists of common diseases, emergency diseases, chronic high-tech services accounting for 90% of inpatient and outpatient treatment costs.
2.6. Develop, update and issue guidelines for diagnosis and treatment, technical procedures, nursing care, and professional procedures in accordance with the above lists (2.5).
2.7. Update the above guidelines every 2 years. Develop technical guidelines for diseases, techniques accounting for 80% of inpatient and outpatient treatment costs.
2.8. Survey satisfaction of patients and healthcare workers.
2.9. Develop database on manpower, finance and professional activities of healthcare institutions and software supporting doctors in examination and treatment.

3.5. Create quality rewards for healthcare institutions;
3.6. Implement national QI programs in: nursing care, clinical nutrition, infection control, rational drug use, voluntary incident reporting system.
3.7. Develop and implement some clinical accreditation programs in some specialties, common diseases and chronic diseases.
3.8. Develop a pilot project for healthcare technology evaluation.
**TENTATIVE ACTIVITIES**

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

- Develop and implement communication projects to raise awareness of healthcare quality for healthcare managers, hospital leaders, healthcare institutions and practitioners.
- Develop and implement communication projects to raise awareness of healthcare quality, rights and responsibilities in healthcare services for patients and community.

**TENTATIVE ACTIVITIES**

- Introduce and disseminate quality initiatives. Make plans and organize study visits to healthcare institutions that are successful in QM in the country.
- Organize regular workshops and forums on hospital QM to share information, models and QI initiatives of some hospitals to others.
- Vote for and award annual hospital quality prize.

**DRAFT LIST OF NEW ADDITIONAL CRITERIA IN 2016**

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

**Scientific research and training**
- Implementing training tasks

**Towards patients**
- Patients benefit from charity programs and social work.
- Directing healthcare activities to other levels

**Towards healthcare workers**
- Surveying healthcare workers’ satisfaction.

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

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

Volume 1

HOSPITALS SURVEY SATISFACTION OF PATIENTS AND HEALTHCARE WORKERS

Survey toolset was issued with Decision number 1334/QD-BYT dated 6 November 2015.

Hospitals survey by themselves and the evaluation team conducts an independent survey and compares with hospital’s results when evaluating hospital quality.


Patient satisfaction

An important criterion to evaluate the hospital’s prestige and services quality.

A measure reflecting the outcomes of public and private healthcare institutions.

Final goal of hospitals

PATIENT SATISFACTION


Healthcare workers’ satisfaction

Human resource: THE MOST IMPORTANT RESOURCE

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

increasing patient satisfaction


Obstetrics

Developing systems for reporting and collecting data of 5 obstetric complications, including those leading to maternal mortality.

Utilizing prophylactic antibiotics in obstetric and gynecologic operations and procedures.

Controlling appropriate rates of Caesarian section.

Capacity of pregnancy management system.

Capacity to care for newborns and premature babies.


ESTABLISHMENT OF PATIENT FEEDBACK SYSTEM

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


HOSPITALS SURVEY SATISFACTION OF PATIENTS AND HEALTHCARE WORKERS

Thank you very much and wish all participants have exciting and fruitful discussions!

Dr. Luong.kcb@gmail.com
Objectives:

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

Program:

1. Hospital Tour
   - Place: Ninh Binh Provincial General Hospital
   - Date: 19th January 2016

2. Forum: Presentations and discussion
   - Place: Bach Mai Hospital
   - Date: 20th - 21st January 2016

Participants:

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

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

## Program 20/01/2016

<table>
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<tr>
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<tr>
<td>08:00 - 08:30</td>
<td>Reception</td>
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<tr>
<td>08:30 - 08:35</td>
<td>Opening speech</td>
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<td>08:35 - 08:50</td>
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<tr>
<td>08:50 - 09:30</td>
<td><strong>Session 1: Learning culture in hospital</strong></td>
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|              | Challenges in shifting from punishment culture to learning culture to improve patient safety  
|              | Dr. Le Viet Nho, Vice Director, Head of Quality Management Department, Quang Nam Central General Hospital |
| 09:35 - 10:15 | **Session 2: Establishing incident reporting system in hospital**        |
|              | Establishment of medical incident management system in Bach Mai Hospital  
|              | Dr. Nguyen Thi Huong Giang, Head of Quality Management Department, Bach Mai Hospital |
| 10:15 - 10:30 | Tea break                                                                |
| 10:30 - 11:10 | Developing incident reporting system in Ha Nam Provincial General Hospital  
|              | Dr. Phan Anh Phong, Vice Director, Ha Nam Provincial General Hospital   |
| 11:15 - 11:55 | Discussion                                                               |
| 12:00 - 13:30 | Lunch                                                                    |
| 13:30 - 14:10 | **Session 3: Improving compliance to timing standard**                    |
|              | Improving compliance to standard emergency response time from 55% to 85% in December 2016  
|              | Dr. Pham Viet Thai, Head of Quality Management Department, Ninh Thuan Provincial General Hospital |
| 14:10 - 15:30 | Tea break                                                                |
|              | **Discussion**                                                           |
| 14:30 - 15:10 | Eight core values in quality management in Japan                         
<p>|              | Dr. Shinsuke Murai, National Center for Global Health and Medicine, Japan |
| 15:10 - 16:00 | Discussion                                                               |</p>
<table>
<thead>
<tr>
<th>Session 4</th>
<th>Improving service quality in OPD</th>
</tr>
</thead>
</table>
| 08:50 - 09:10 | Plan to improve management and medical safety in dispensing drugs to patients in Outpatient Department  
*Dr. Tran Quang Hien,  
Director, An Giang Hospital of Obstetrics, Gynecology and Pediatrics* |

<table>
<thead>
<tr>
<th>Session 5</th>
<th>5S</th>
</tr>
</thead>
</table>
| 09:15 - 09:55 | 5S implementation in two departments in Ninh Binh Provincial General Hospital (Nephro-urological Surgery and Endocrinology Departments)  
*Dr. Vu Thuy Giang,  
Head of Quality Management Department, Ninh Binh Provincial General Hospital* |
| 09:55 - 10:10 | Tea break |
| 10:10 - 10:50 | 5S implementation in Ha Dong General Hospital  
*Dr. Nguyen Thi Huong Lien,  
Head of Quality Management, Dong General Hospital* |
| 10:55 - 11:35 | Project for 5S implementation in Thai Binh Provincial General Hospital  
*Dr. Tran Thi Quynh Anh,  
Deputy Head of Quality Management Department, Thai Binh Provincial General Hospital* |
| 11:40 - 13:30 | Lunch |
| 13:35 - 14:00 | 5S  
*Ms. Megumi Ikarashi, Bureau of Medical International Cooperation, National Center for Global Health and Medicine, Japan* |

<table>
<thead>
<tr>
<th>Session 6</th>
<th>Improving quality in clinical departments</th>
</tr>
</thead>
</table>
| 14:00 - 14:40 | Reducing ventilator associated pneumonia by 5% and pressure ulcer by 10% in ICU within three months  
*Dr. Tran Quang Dat,  
Deputy Head of Quality Management Department, Quang Nam Central General Hospital* |
| 14:45 - 15:25 | Increasing the rate of proper use of prophylactic antibiotics in surgery after one PDCA cycle  
*Dr. Ton Thanh Tra,  
Head of Quality Management Department, Cho Ray Hospital* |
| 15:25 - 15:30 | Tea break |

<table>
<thead>
<tr>
<th>Session 7</th>
<th>Updates from the Ministry of Health</th>
</tr>
</thead>
</table>
| 15:30 - 16:00 | Applying Hospital Quality Standards to improve hospital quality and patient care  
*Dr. Duong Huy Luong,  
Medical Services Administration, Vietnam Ministry of Health* |
| 16:00 - 16:25 | Discussion |
| 16:25 - 16:30 | Closing |
Steering Committee

1. Hospital Tour (19 January 2016)
   Ninh Binh Provincial General Hospital
   Dr. Vu Thuy Giang, M.D., MSc.

2. Presentations (20-21 January 2016)
   Dr. Nguyen Thi Huong Giang, M.D., MSc.
   Dr. Le Viet Nho, M.D., PhD.
   Dr. Phan Anh Phong, M.D., MSc.
   Dr. Pham Viet Thai, M.D.
   Dr. Shinsuke Murai, DDS., PhD.
   Dr. Tran Quang Hien, M.D., PhD.
   Dr. Vu Thuy Giang, M.D., MSc.
   Dr. Nguyen Thi Huong Lien, M.D., MSc., 2nd Degree Specialist
   Dr. Tran Thi Quynh Anh, M.D., 1st Degree Specialist
   Dr. Tran Quang Dat, M.D., 2nd Degree Specialist
   Dr. Ton Thanh Tra, M.D., MSc.
   Ms. Meguma Ikarashi
   Dr. Duong Huy Luong, M.D., PhD.

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

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   Ms. Pham Thi Phuong Thuy, MPH.
   Dr. Nguyen Thi Le Hang, M.D., PhD.
   Ms. Le Thi Thu Phong

5. Coordinator
   National Center for Global Health and Medicine (NCGM)
   Dr. Shinsuke Murai, Course Director, Strengthening Health Staff’s Capability of Quality Management and Patient Safety in Healthcare Program
   Ms. Megumi Ikarashi, Bureau of International Health Cooperation

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

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Affiliation</th>
<th>Role</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Duong Huy Luong</td>
<td>Medical Services Administration, Ministry of Health (MOH)</td>
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<td>Le Viet Nho</td>
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<td>3</td>
<td>Nguyen Thi Huong Giang</td>
<td>Bach Mai Hospital</td>
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<td>Nguyen Thi Huong Lien</td>
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<td>Pham Viet Thai</td>
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<td>Nguyen Thi Tuoi</td>
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<td>Quy Hoa Central Leprosy-Dermatology Hospital</td>
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<td>Nguyen Dinh Hung</td>
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<td>Observer</td>
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<td>Lu Quoc Hung</td>
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<td>Pham Huu Thuong</td>
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<td>41</td>
<td>Cao Hung Thai</td>
<td>MOH</td>
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<td>Nguyen Trong Khoa</td>
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<td>Dao Minh Nguyet</td>
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<td>Do Hong Phuong</td>
<td>UNICEF</td>
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<td>Pham Van Man</td>
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<td>Luong Van Long</td>
<td>Dien Bien</td>
<td>Observer (JICA)</td>
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<td>Lao Cai</td>
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<td>51</td>
<td>Nguyen Duc Diep</td>
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</tr>
<tr>
<td>52</td>
<td>Cao Ngoc Thanh</td>
<td>Yen Bai</td>
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<tr>
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<td>Bui Ngoc Quynh</td>
<td>Yen Bai</td>
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</tr>
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<td>Sa Ngoc Hung</td>
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<td>Truong Quy Duong</td>
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<tr>
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<td>Do Thi Duong</td>
<td>Lai Chau</td>
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</tr>
<tr>
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<td>Kyoko TAKASHIMA</td>
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<td>Observer</td>
</tr>
<tr>
<td>60</td>
<td>Shinsuke MURAI</td>
<td>NCGM</td>
<td>Staff</td>
</tr>
<tr>
<td>61</td>
<td>Megumi IKARASHI</td>
<td>NCGM</td>
<td>Staff</td>
</tr>
<tr>
<td>62</td>
<td>Nguyen Thi Le Hang</td>
<td>MCC</td>
<td>Staff</td>
</tr>
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<tr>
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</tr>
<tr>
<td>66</td>
<td>Mr. Chau</td>
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<td>Photographer</td>
</tr>
</tbody>
</table>

Volume 1


Edited by Ms. Hong-Anh Nguyen¹ and Dr. Shinsuke Murai²

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