12 Patient safety in Thailand

By. Piyawan Limpanyalert

Introduction

Thailand has increasingly recognized patient safety as a crucial healthcare issue. Special efforts have been undertaken to improve the healthcare system to ensure the delivery of quality services. Patient safety is, fundamentally, a dimension of healthcare which fulfils the needs of both service providers and users. The Ministry of Public Health (MOPH), healthcare professional councils and other responsible agencies in the healthcare system (public and private), communities and civil societies are becoming involved in collaboratively creating a better and safer healthcare system. In Thailand, the Healthcare Accreditation Institute Public Organization (HAI) has legislative responsibility for quality improvement and accreditation of health care organisations. Thus, the HAI has been both a driver and an active participant in the patient safety movement. This chapter begins by sketching the patient safety profile of Thailand, drawing upon available empirical data. It then provides an account of the HAI's initiatives for promoting patient safety in the country, including (i) tools and mechanisms to promote patient safety in hospitals and (ii) programmers and mechanisms to promote patient safety in the healthcare system. The chapter concludes by sharing the lessons that have been learned through the patient safety movement and identifies a number of factors critical for the success in promoting patient safety in Thailand, but also elsewhere in the world.

Thailand's patient safety profile

Traditionally, national statistics on patient safety in Thailand have been limited. Nevertheless, since 2006, there has been an effort to build a national data collection system. The MOPH surveyed adverse events (AEs) across the country, finding 207,073 AEs reported from 389 hospitals.' The top three AEs were medical error, problems with communication and the care process. Community ais had more AEs than provincial and central hospitals in all risk areas. Thailand has had a system to review patient complaints, and a compensation scheme, since 2004. Data from the National Health Security Office showed that, in 2016, the Office paid relief money to 885 patients and/or their families who suffered from undesirable consequences of medical practices, with an average of USD 7,200 per case,' a figure which has risen 40 times in

the last 10 years. The top three medical departments that were complained against were Obstetrics and Gynecology (36.8%), Surgery (14.9%) and Internal Medicine (10.5%). To some extent, compensation can relieve the financial burdens incurred by some patients and families as a result of medical errors. However, the determinant of medical error is an evaluation of the standard of care which the patient received, assessed from a clinical perspective focus. This raises an underlying question about whether the patient experience of safety is fully realised through a system of compensation for medical liabilities. Arguably, only a more proactive, systemic approach towards patient safety can address the complexities of quality and safety in healthcare. Thailand has begun to implement a more holistic approach through a variety of patient safety initiatives.

Patient safety initiatives

The HAI has carried out numerous initiatives, including the development tools and mechanisms for promoting patient safety in hospitals and the healthcare system. In 2012 the HAI established the Community of Practice, a knowledge exchange mechanism, in four high-risk areas (Emergency Room, Labour Room, Operating Room and Intensive Care Unit) to engage experts and healthcare workers in sharing their experiences and examples of good practice guidelines In 2013 the HAI set up a monitoring system, through the Thailand Hospital
Indicators Project to benchmark healthcare outcomes.

Despite these efforts, improvement in patient safety has been slow; Thailand still has problems of AEs and medication errors. The engagement of all stake holders and participants is essential to improve patient safety. In order to tackle this issue, the Engagement for Patient Safety Programme was initiated in 2014. Consequently, the Patient and Personnel Safety policy was recently issued by the MOPH as a result of this engagement.

Quality tools and mechanisms to promote patient safety in hospitals

The HAI's initial work on patient safety focused on quality improvement in hospitals. It encourages quality assurance through hospital accreditation alongside the use of quality tools/mechanisms such as quality review activities, the adoption of the Thailand Patient Safety Goals and Trigger Tools.

Reference: Global Patient Safety Law, Policy and Practice

Hospital accreditation

The HAI has been using hospital standards to drive quality improvement since 1997. The HAI, in performing its function as an accrediting body, promotes quality improvement and patient safety using self-assessment and self-improvement, along with external evaluation and recognition as an incentive. The accreditation programme takes a three-step grading approach to hospital accreditation (HA) recognition.[3] For Step One, in applying for HA, healthcare organisations have to identify and review their risk profiles and determine an agreed approach to minimization of key risk areas. Healthcare practitioners are encouraged to embed quality review activities into routine activities. In order to be eligible for step two recognition, the HAI encourages them to improve their systems to meet the HA standards including the risk management system, infection control system, medication management system, the system of safe environment of care, and patient care processes. After they had improved and produced quality and safe outcomes, they would be awarded with Step Three recognition. As of October 2017, the percentage of fully accredited hospitals is now 55%, and nearly 10% are at the second step of HA recognition; indicating that nearly 65% of all hospitals in Thailand have developed some form of risk management system.

Patient safety, therefore, has been significantly enhanced through the introduction of a risk management system and an accreditation process. Patient safety is a fundamental component that HAI surveyors must assess during their visits for hospital accreditation. Hospital staff are guided on developing incident report systems. Data on AEs in a hospital, their root cause analysis and opportunities for improvement are discussed during the surveyors' visit.

Thailand patient safety goals: SIMPLE

In 2008 the HAI, in collaboration with key stakeholders, developed the 'SIMPLE' guidebook on patient safety goals.* SIMPLE is an acronym of six key issues that should be highlighted when promoting patient safety. These are:

S = Safe surgery

I= Infection control

M = Medication and blood safety

P = Patient care process

Reference: Global Patient Safety Law, Policy and Practice

L= Line, tubing and catheter and laboratory

E = Emergency response.

Thailand Patient Safety Goals' is an attempt to ensure that all healthcare organisations have a set of shared safety priorities and a practical safety guideline for major risk areas. These goals were developed using survey data, academic data and related guidance documents from within and outside the country. These were also consistent with the directions of the World Health Organization's (WHO) Global Patient Safety Challenges and Patient Safety Solutions.[6]

Within the SIMPLE framework, each healthcare organization is able to pursue their patient safety interests or needs by setting their own safety goals and establishing practical guides, then implementing and evaluating these in their operations. Healthcare organisations are also encouraged to use quality tools for learning and improving their system for safety, such as using 'root cause analysis to analyses the causes of AEs and the Trigger Tool to identify major risks from medical records for review.

Trigger Tool

Setting up an effective incident report system in a hospital usually takes time. Under-reporting is generally a challenge, either because hospital staff do not recognize the importance of this data for quality improvement, or when they are involved in any AEs, they may be afraid of 'punishment' in the form of litigation. Trigger Tools were initially developed by the Institute for Healthcare Improvement, an international quality improvement agency, to sample medical records to proactively identify AEs which have not been reported, rather than waiting for reports from the incident report system.' The HAI adapted this international tool to fit the national context, and introduced the Trigger Tool to the hospitals that underwent the quality improvement journey in 2007.

Programmes and mechanisms to promote patient safety in the healthcare system

The HAI broadened its patient safety work outwards from the hospital level to the whole health care system. The MoPH issued a 10-year plan for coordinating the movement on patient safety (see Table 12.1). In addition, the HAI also supported the development of the "Thailand Hospital Indicator Project' and the "Community of Practice' to empower health professionals. Moreover, realising that quality of healthcare and patient safety requires engagement by all stakeholders

within and outside the health sector, an 'Engagement for Patient Safety' project was therefore initiated.

Long-term plan for promoting patient safety

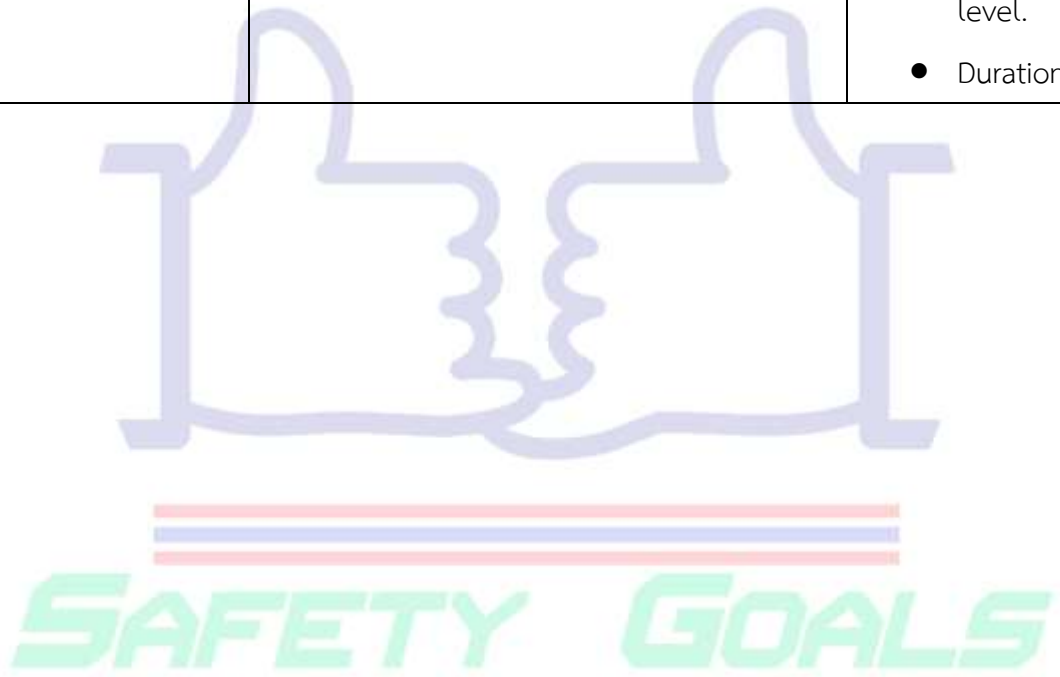
In the systematic development of the 10-year plan for ongoing improvement of patient safety in Thailand, the setting of targets was done with cooperation from all sectors. Consequently, various movements/mechanisms for patient safety were integrated into the plan. Many organisations have collaboratively launched various programmes and projects for improving the quality of care and patient safety. Proposed actions during 2015-2024 are summarized in Table 12.1.

Reference: Global Patient Safety Law, Policy and Practice

The Decade of Improving the Quality of Care and Patient Safety		
Phase 1 (2015-2017)	**Phase 2 (2018-2021)**	**Phase 3 (2022-2024)**
• Raise awareness and clarify understanding about patient safety among health personnel and general public. • Develop tools, mechanisms, systems, bodies of knowledge, and models. Piloting on voluntary basis in various participatory forms of the implementation about patient safety. • Establish a network of organisations, agencies and people. Build up the leading teams in various aspects of patient safety for driving the movements as a whole. • Have a patient safety goal (or target) in place at national level. Initiate a systematic research and develop a	• Educational Institutions integrate the teaching of patient safety in their curriculum, covering all institutions. • Scale-up the implementation of "Hospital for Patient Safety" as a policy covering all healthcare organisations. • . Special interest group drives a move on patient safety covering all regions of health providers. • Have a system to evaluate and monitor incident reporting database; have an indicator system to compare the quality of clinical outcomes at the national level. • Have a structure for the improvement of patient safety in	• Create safety innovations in healthcare system • Ensure the inclusiveness of patient safety covering health promotion, treatment, prevention and rehabilitation. • All people are engaged in the improvement of health service system. • Healthcare organisations awarded with healthcare accreditation have quality and patient safety outcomes for publicizing in public media. • Have a system for giving feedback and awarding the recognition by general public.

Reference: Global Patient Safety Law, Policy and Practice

policy recommendation for improvement in phase 2. • Propose and participate in the movements at the ministerial and regional levels. • Duration = 3 years.	healthcare organisations; and have a legal protection for quality-improvement data. • Propose and participate in the movements of patient safety at the global level. • Duration = 4 years.	• Have the outcomes from systematic research regarding quality and patient safety at national level. • Serve as the prototype of outcome-oriented model for driving the movement on patient safety; and have a safety culture at the global level. • Duration = 3 years.



Reference: Global Patient Safety Law, Policy and Practice