Healthcare Organization Commitment

Contact Details

Name
Tai-Hung, Kuo

Phone
+886 6-9261151 #50501

Email
dire@pngh.mohw.gov.tw

Position
superintendent

Organization Name
Penghu Hospital, Ministry of Health and Welfare

Organization Address
Penghu County, Magong City
880
Taiwan

Commitment Details

Commitment Name
Creating a culture of safety in Penghu hospital

Participants
Chang, Tsun TZU

What Patient Safety Challenge does your Commitment address?
Challenge 1 - Creating a Foundation for Safe and Reliable Care

How Many Hospitals Will This Commitment Represent
**Action Plan**

Five ways of Penghu Hospital to create trustworthy patient safety culture: 

- Creating mutual trust in the organization to promote care and integrity is the core value of Penghu Hospital: 1. Creating a safe medical environment. 2. Building SOP for safety patient care. 3. Employees are responsible for automatically reporting incidents and identifying strategies to promote patient safety. In conclusion, establishing mutual trust between patients and medical staff and perfecting patient care are our goals. 

- Establishment of accountability: 1. Promoting patient safety aggressively. The superintendent of Penghu Hospital is responsible for medical quality management and actively participates in promoting patient safety. 2. The establishment of the medical quality and patient safety committee. The committee is held regularly. 

- Encourage reporting of patient safety events: 1. Reward reporting of patient safety events. 2. Establish mechanism to educate and train medical team members. 3. Participate in TPR notification software system to learn from one defect per month. 

- Creating patient safety culture: 1. Use Team Resource Management (TRM) to strengthen the effective communication and teamwork between medical teams. 2. Promote the sharing of medical decision-making (Shared Decision Making, SDM): constitute the SDM team, provide related information actively, and promote SDM. 3. Participate patient safety culture survey, perform post-test, and analyze the data. 

- Regular Evaluation and continual improvement of organizational patient safety culture. The meeting to trace performance is held every 3 months. Regularly discuss the safety events and through IDT analyses, SAC status determination, sentinel events investigation to improve patient safety.

**Commitment Timeline**

We started this commitment since on January 1st, 2017.

**Impact Details**

- **Lives Lost in Last Calendar Year**
  
  120

- **How many lives do you expect to spare from harm in the next calendar year?**
  
  2

- **How many lives do you expect to save in the next calendar year?**
  
  5

**Methodology for Determining Lives Saved**

We didn't use a methodology other than the one PSMF provided.