LIVE 26th July 2023

10:00-11.00

ECRI

US Expert Speaker Live Show

-Total Systematic Approach to Patient Safety

-Patient Safety in the US

Dr. Marcus Schabacker

(President and Chief Executive Officer of ECRI)

TH Expert Speaker Live Show

-Patient Safety in Thailand (3P Safety)

- TOP 10 Patient Safety Report 2023

Dr. Piyawan Limpanyalert

(Chief Executive Officer of HAI Thailand)

Patient Safety in Thailand and Top 10 Patient Safety Report 2023

Dr.Piyawan Limpanyalert, MD

CEO of the Healthcare Accreditation Institute, Thailand

Journey of patient and personnel safety in Thailand

1997-present	2013-2015	2016	2017-2018	2018-2020	2022
Integrated quality and safety in hospital development for Hospital Accreditation	Engagement for Patient Safety program	Country self-assessment for Patient Safety Announcement National Policy	National Committee National Strategy and National Goals	2P Safety Hospital Project and World Patient Safety Day	Integrated in Hospital standards and criteria for accreditation

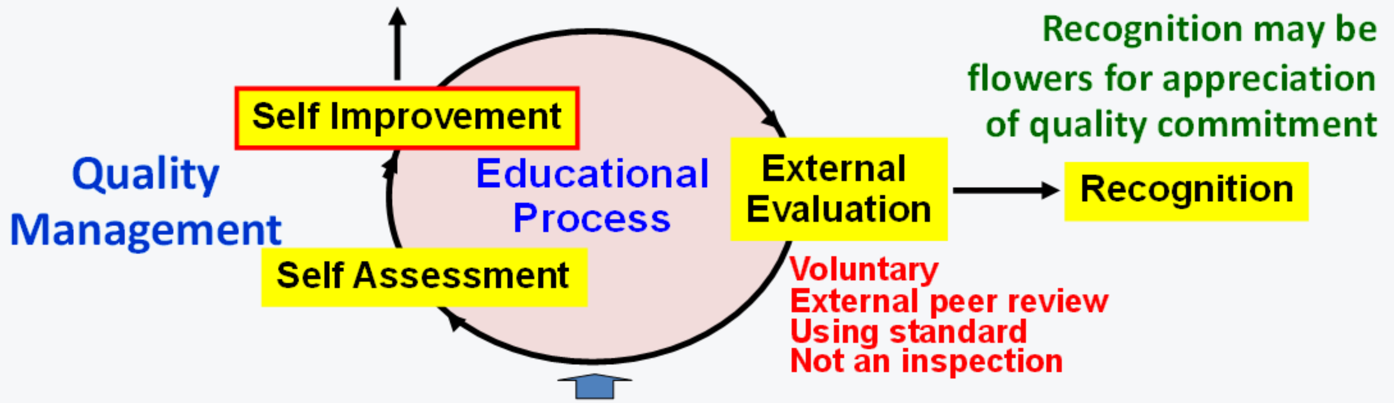
	Step 1	Step 2	Step 3
Overview	Reactive	Proactive	Quality Culture
Starting Point	Review Problems & Adverse Events	Systematic Analysis of Goal & Process	Evaluate Compliance with HA Standards
Quality Process	Check-Act-Plan-Do	QA: PDCA CQI: CAPD	Learning & Improvement
Success Criteria	Compliance with Preventive Measures	QA/CQI Relevant with Unit Goals	Better Outcomes
HA Standard	Not Focus	Focus on Key Standards	Focus on All Standards
Self Assessment	To Prevent Risk	To Identify Opportunity for Improvement	To Assess Overall Effort & Impact of Improvement
Coverage	Key Problems	Key Processes	Integration of Key Systems

Thailand Self-Assessment for Patient Safety Situation

Strategy Number	Strategic Direction	Total Marks	Marks Scored	Assessment	Comments
1	Strategic Direction 1	52	38		Good, need to expand
1.1	Legal and Regulatory Framework	32	25		Excellent, and maintain
1.2	Accreditation and External Quality Assessment	12	9		Good, need to expand
1.3	Safety Culture at HCF	4	3		Good, need to expand
1.4	Patient Involvements in PS and Care	4	1		Weak, need attention
2	Strategic Direction 2	12	3		Weak, need attention
2.1	Adverse Events Monitoring	12	3		Weak, need attention
3	Strategic Direction 3	32	15		Fair and room to improve
3.1	Competent Workforce	16	9		Good, need to expand
3.2	Patient Safety Risk Management	16	6		Fair and room to improve
4	Strategic Direction 4	40	38		Excellent, and maintain
4.1	Infection Prevention and Control	28	26		Excellent, and maintain
4.2	Sterilized Equipment	4	4		Excellent, and maintain
4.3	Environment, General Hygiene and Sanitation	8	8		Excellent, and maintain
5	Strategic Direction 5	80	61		Excellent, and maintain
5.1	Safe Surgical Care	8	5		Good, need to expand
5.2	Safe Childbirth	8	6		Good, need to expand
5.3	Safe Injection	16	14		Excellent, and maintain
5.4	Safe Medication	4	2		Fair and room to improve
5.5	Blood Safety	4	3		Good, need to expand
5.6	Medical Devices Safety	8	7		Excellent, and maintain
5.7	Safe Transplantation	32	24		Good, need to expand
6	Strategic Direction 6	12	6		Fair and room to improve
6.1	Research Capacity	12	6		Fair and room to improve

Integrated quality and safety in hospital development for Hospital Accreditation

- The Healthcare Accreditation Institute (Public Organization) or HAI has legislative responsibility for quality improvement and accreditation of health care organizations in Thailand.
- The HAI has been actively involved in the patient safety movement through the process of hospital accreditation (HA) and various quality improvement initiatives.



Core Concepts:
Flexible, context oriented
System approach, integration
Positive approach
Evaluation to stimulate improvement
Special character of healthcare (uncertainty, autonomy & accountability)

HA as an Educational Process

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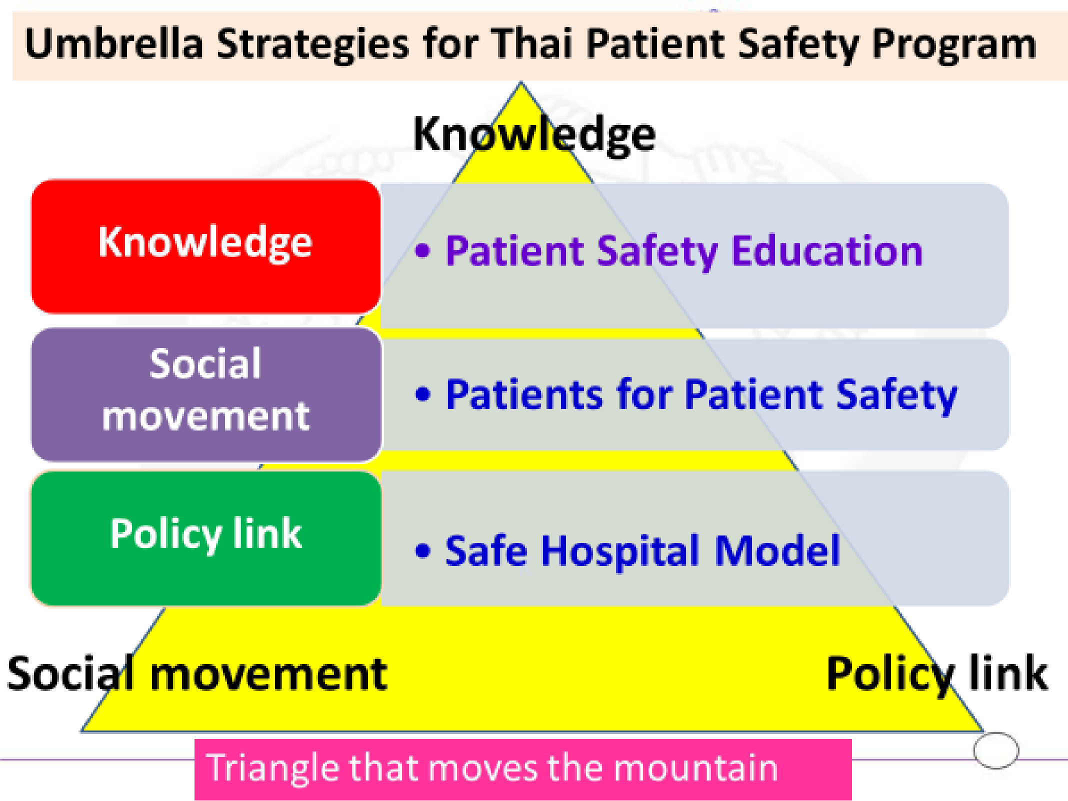
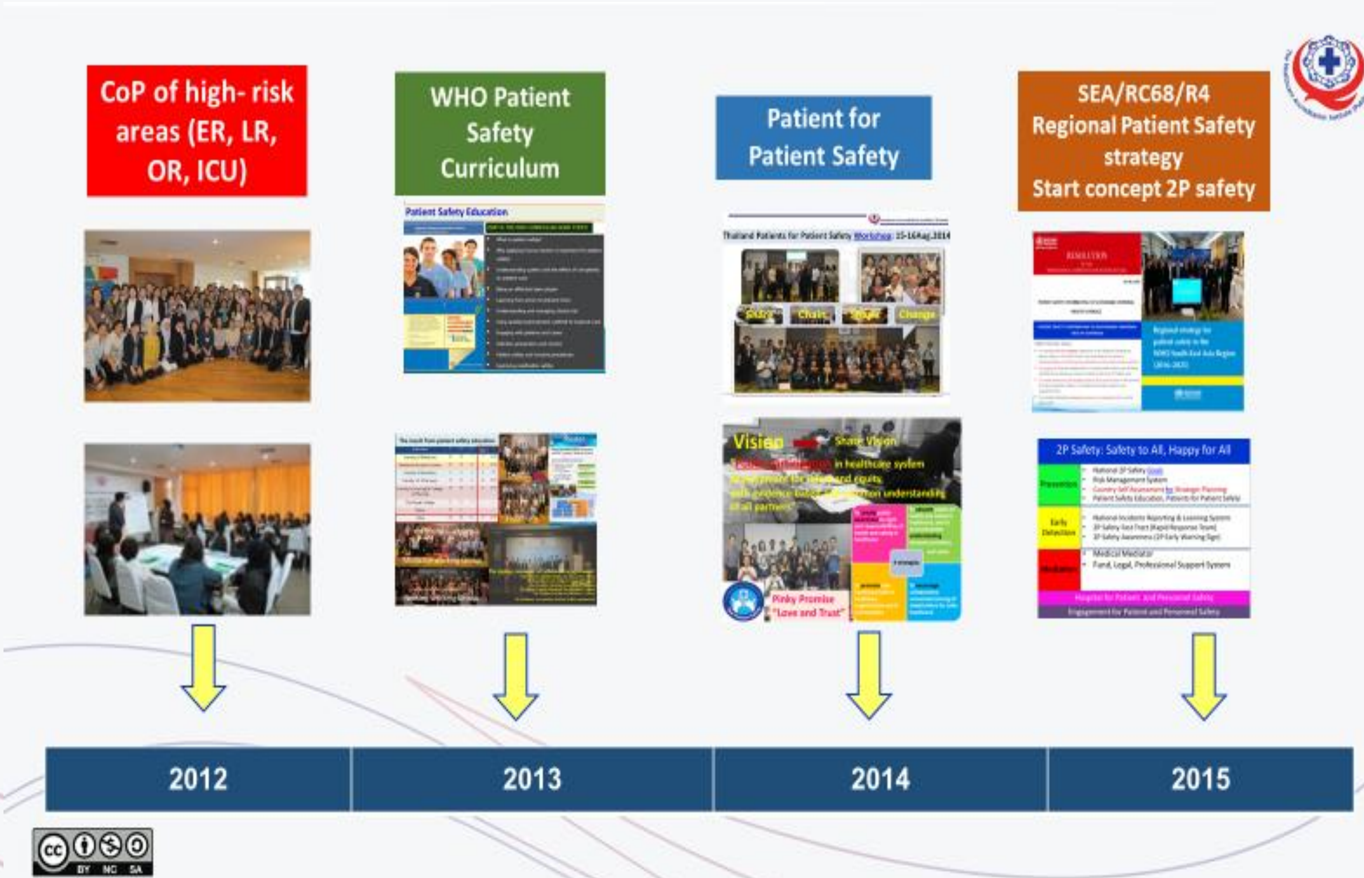
Engagement for Patient Safety program

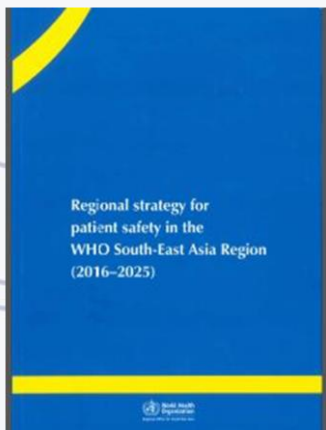
Engaged professionals ,Experts, Healthcare personnel, patients, family, policy maker, stakeholder both health and non-health





Country self-assessment for Patient Safety

The Thailand-self assessment committee in finalization of the results on 16 Sep 2016



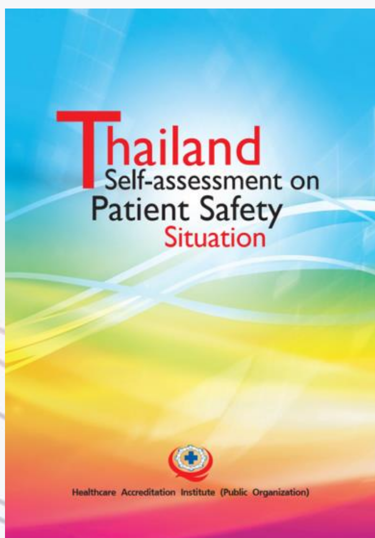


Table 3. 1 The summary dashboard of Thailand self-assessment results

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Announcement National Policy

National Patient and Personal (2P) Safety Policy

- All key stakeholders agreed to place an emphasis on personal safety improvement in parallel with patient safety improvement.
- After the final assessment was done on 16 September 2016, the National Policy on Patient and Personnel (2P) Safety was formally announced to the public by H E Clinical Professor Emeritus Dr. Piyasakol Sakolsatayadorn, Minister of Public Health (MOPH).

13

3 main objectives of the 2P Safety policy:

1. To aim at achieving the **national patient and personnel safety goals** with strategic movement developed by the full, active participation of all key stakeholders.
2. To promote the development of **national incidents reporting and learning system** under collaboration between health personnel and all related organizations at the local, regional and national levels.
3. To encourage the **engagement of patients and population** in developing safety health systems in a creative manner.

Note: 15 organizations (e.g. MOPH, Health professional councils, National Health Commission, Foundation of Consumer Protection…, and HAI) **signed the MOU in moving forward the 2P safety policy into actions.**

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Engagement of all

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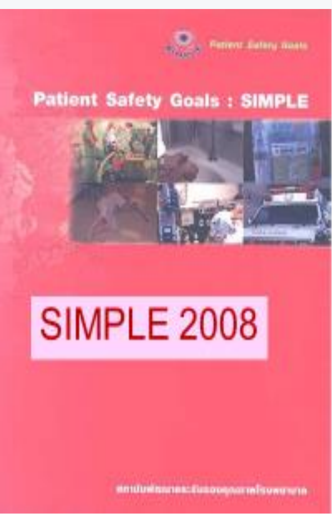
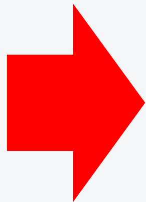
Announcement National Strategy

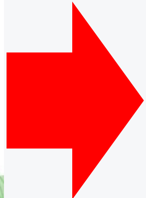
Announcement of 2P Safety Strategy on "Thailand Patient and Personnel Safety Day: 17 September 2017"

Engagement of all → National Policy → National Committee → National Strategy → National Goals

Announcement Thailand Patient and personnel safety Goals







	Patient Safety Goals		Personnel Safety Goals
S	Safe Surgery and Invasive Procedures	S	Security and privacy of information and Social Media (communication)
I	Infection Prevention and Control	I	Infection and Exposure
M	Medication & Blood Safety	M	Mental Health and Mediation
P	Patient Care Processes	P	Process of work
L	Line, Tube & Catheter, Device and Laboratory	L	Lane (ambulance), Legal Issues
E	Emergency Response	E	Environment & Working conditions

Each healthcare organization could pick up the topics of their interest to set as their safety goals and practical guides; then apply these in their operations and evaluate the achievement of these goals in accordance with their contexts.

Engaged of experts in different areas to co-working

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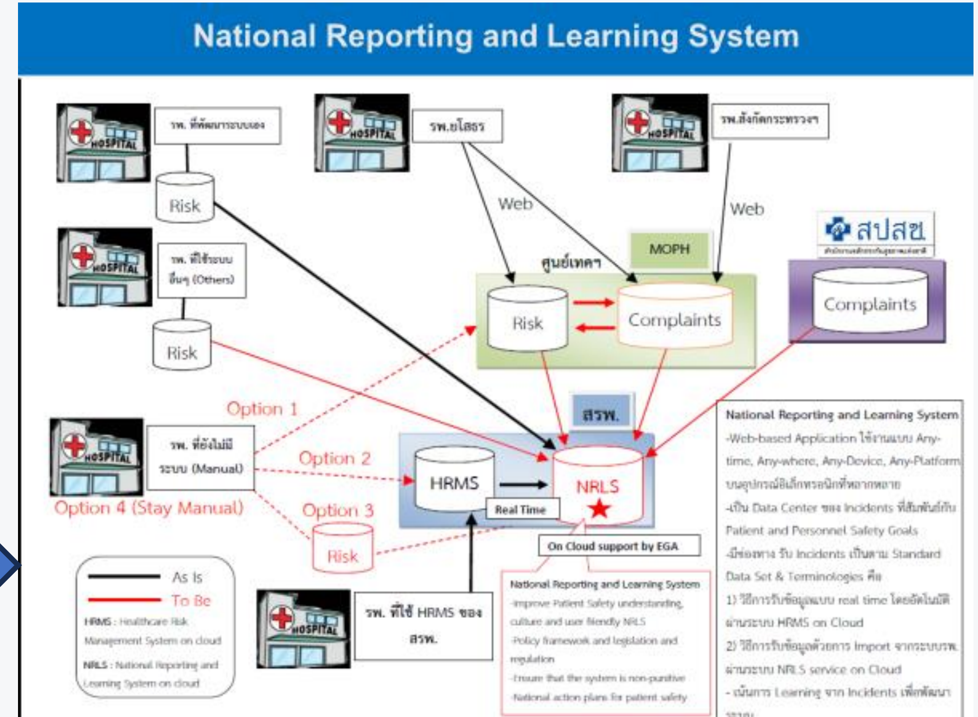
WHO Propose a minimal common architecture for incident reporting systems in 2005 and 2009.

Led to the formulation of the Minimal Information Model for patient safety incident reporting and learning system (MIM PS). Assist countries to establish systems of reporting in order to allow aggregation and analysis of data at a higher level.

Published in 2020 by WHO to provide practical guidance on establishment and effective use of PSI RLS



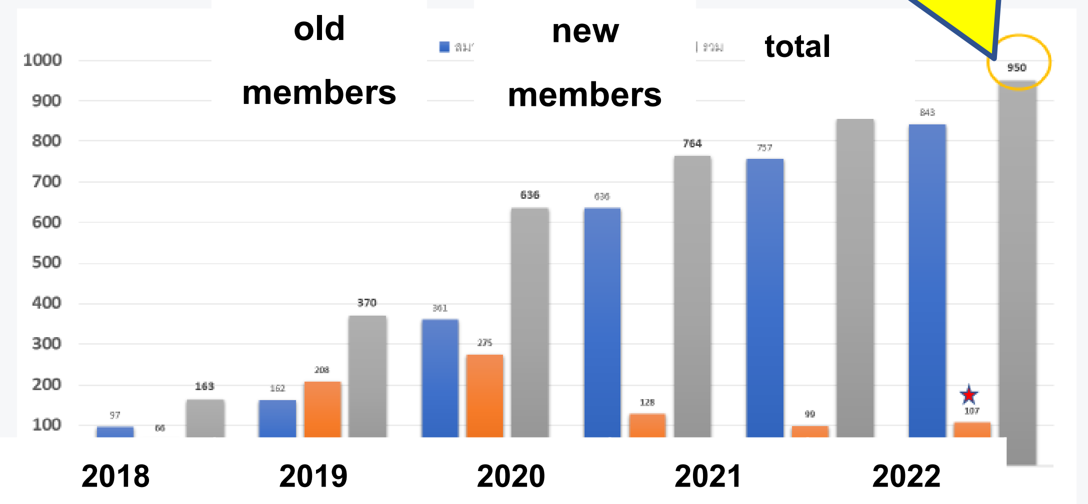
From Global to National Policy: National Reporting and Learning System

“2P Safety Hospitals” as a platform for implementation and “World Patient Safety Day” for sharing and recognition

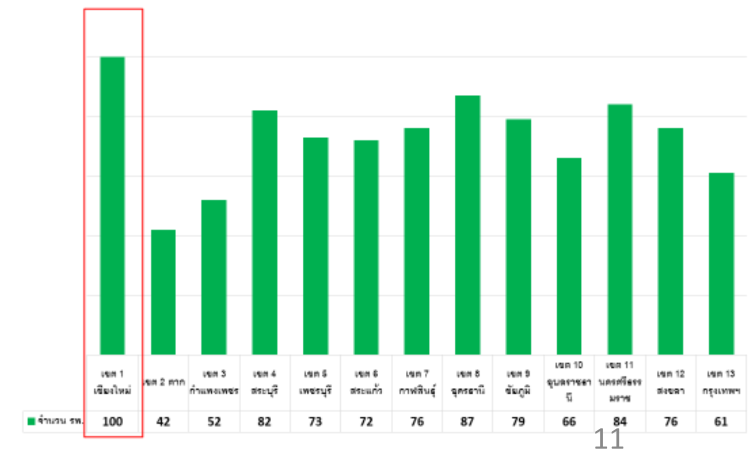
64.6% from 1,471 hospitals

2P Safety Hospitals

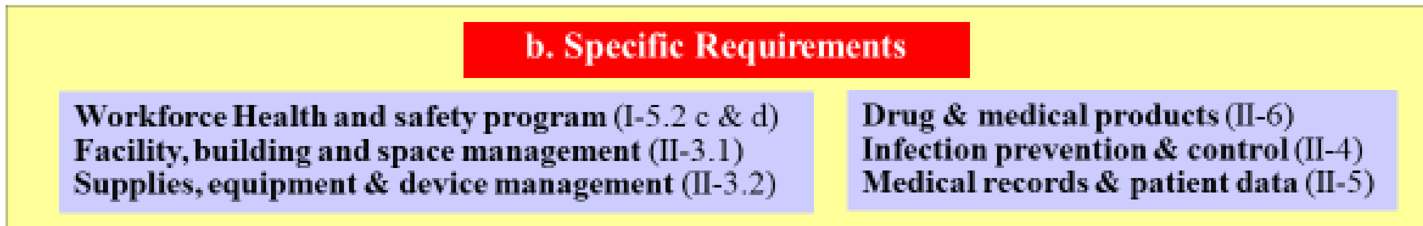
- 950 voluntary hospitals
- Leader announced 2P Safety policy and 2P safety Goals in hospitals
- RM in hospital and report incident to NRLS
- Platform for RCA with experts
- Safety Culture survey
- Sharing and Learning in CoPs
- Patient experience program
- World Patient Safety Day
- 2P Safety Tech produced 36 safety innovations



จำนวนโรงพยาบาลสมาชิกระบบ NRLS แยกตามเขตบริการสุขภาพครอบคลุมทั้งประเทศ



Integrated to Hospital Accreditation Standards for sustainability



Integrated 2P safety in HA standards and criteria for Accreditation

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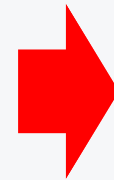
Announcement Essential Standards for Safety as the criteria for accreditation



Essential standards for patient safety

Nine essential standards	Recommendations for hospital
1. A surgery performed to a wrong person, on a wrong side, wrong procedure. 2. Important infections in healthcare organization according to organization, in the group of: SSI, VAP, CAUTI, CABSI 3. Personnel acquire an infection from performing duty. 4. The incident of medication error and adverse drug event. 5. Blood transfusion to a wrong person, or with a wrong group, a wrong type 6. Error in identifying a patient 7. Diagnostic error 8. Error in reporting laboratory/pathological test results 9. Screening error at emergency room	Hospitals must perform the following: 1. Hospitals must have guidelines for preventing patient from harm in nine essential standards. 2. Share the incident number of nine essential standards for patient safety annually . 3. In case of an adverse event affecting the patient (level E or higher), the hospital should review and analyze the root cause 4. Develop a risk management plan and monitor its effectiveness to show with the survey when conducting hospital survey.

SIMPLE Guideline

Incidents report: NRLS

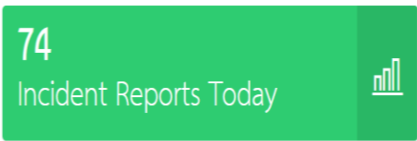
Learning system: NRLS

RM plan and Risk register

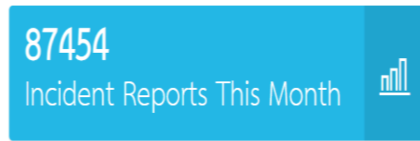
National Patient and Personnel Safety Goals are critical preventable harms by National Patient and Personnel Safety Committee promotes and enforces major changes in the Thai healthcare system.

Selected Thailand Patient and personnel safety Goals 2018 to Essential Standards for Safety

National Reporting and learning System 2018-2022



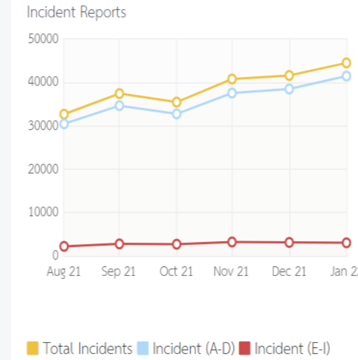
Incident Type	A-D,1-2	E-I,3-5	รวม
Patient Safety Goals หรือ Common Clinical Risk Incident	47	2	49
Specific Clinical Risk Incident	1	0	1
Personnel Safety Goals	17	0	17
Organization Safety Goals	6	1	7
รวม	71	3	74



Incident Type	A-D,1-2	E-I,3-5	รวม
Patient Safety Goals หรือ Common Clinical Risk Incident	58670	4095	62765
Specific Clinical Risk Incident	658	401	1059
Personnel Safety Goals	10063	340	10403
Organization Safety Goals	7440	1644	9084
รวม	76831	6480	83311

Incident Type	A-D,1-2	E-I,3-5	รวม
Patient Safety Goals หรือ Common Clinical Risk Incident	193314	14225	207539
Specific Clinical Risk Incident	1873	1427	3300
Personnel Safety Goals	33555	1207	34762
Organization Safety Goals	24860	4936	29796
รวม	253602	21795	275397

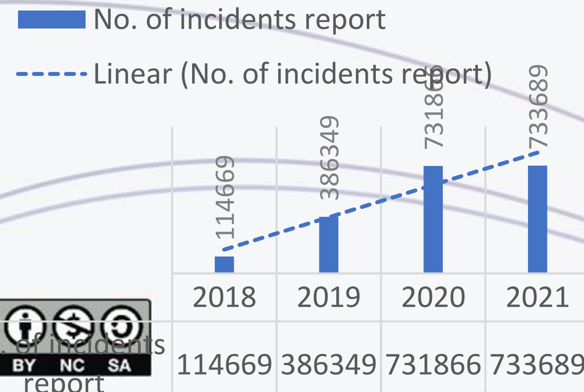
% patient suffering from incidents

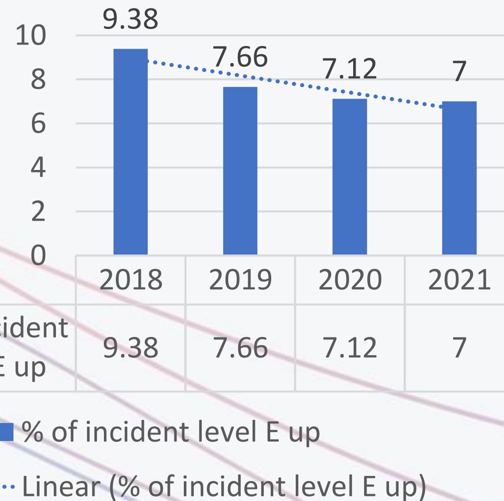


Incident Type	E	F	G	H	I	รวม E-Up	รวม(ระดับ A-I)	ร้อยละ E-Up
Safe Surgery	979	512	39	33	34	1597	8904	17.94
Infection Prevention and Control	1073	431	9	24	51	1588	8679	18.30
Medication & Blood Safety	1455	194	4	23	27	1703	113066	1.51
Patient Care Processes	3253	837	65	236	291	4682	57302	8.17
Line, Tube, and Catheter & Laboratory	1430	122	8	27	13	1600	18736	8.54
Emergency Response	2216	777	114	706	929	4742	10246	46.28
Other (อื่นๆ ซึ่งไม่สามารถจัดเข้า SIMPLE ได้)	699	150	10	104	247	1210	15947	7.59
รวม	11105	3023	249	1153	1592	17122	232880	7.35

Costs lost in case of AE averaged 200,000 baht per case, in 4 year 17,460 incidence of E-up (AE) decrease, that save cost 3,492,000,000 million baht.

2P Safety Gold	Incident	2018	2019	2020	2021	2022
S: Safe Surgery	CPS101 Surgery performed on the wrong body part					
	CPS102 Surgery performed on the wrong patient					
	CPS103 Wrong surgical performed on a patient					
I: Infection and prevention control	CPS111 SSI: Surgical Site Infection					
	CPI201 CAUTI: Catheter Associated Urinary Tract Infection					
	CPI202 VAP: Ventilator-Associated Pneumonia					
	CPI203 CLABSI: Central Line-Associated Bloodstream Infection					
I: Infection and Exposure	GPI201 Airborne transmission					
	GPI202 Droplet transmission					
	GPI203 Contact transmission					
	GPI204 Vector borne transmission					
M: Medication and blood safety	CPM101 Repeated drug allergy					
	CPM201 Medication error : Prescribing					
	CPM202 Medication error : Transcribing					
	CPM203 Medication error : Pre-dispensing					
	CPM204 Medication error : Dispensing					
	CPM205 Medication error : Administration					
	CPM501 Wrong blood tranfused					
P: Patient care process	CPP101 Patient Identification					
	CPP301 Misdiagnosis or delay diagnosis					
L: Lab safety	CPL201 Laboratory error					
	CPL203 Radiographic examination error					
E: Emergency response	CPE402 Under triage					
	CPE403 Over triage					
	CPE405 Delay Diagnosis and Delay treatment					
	CPE407 Missed Diagnosis					





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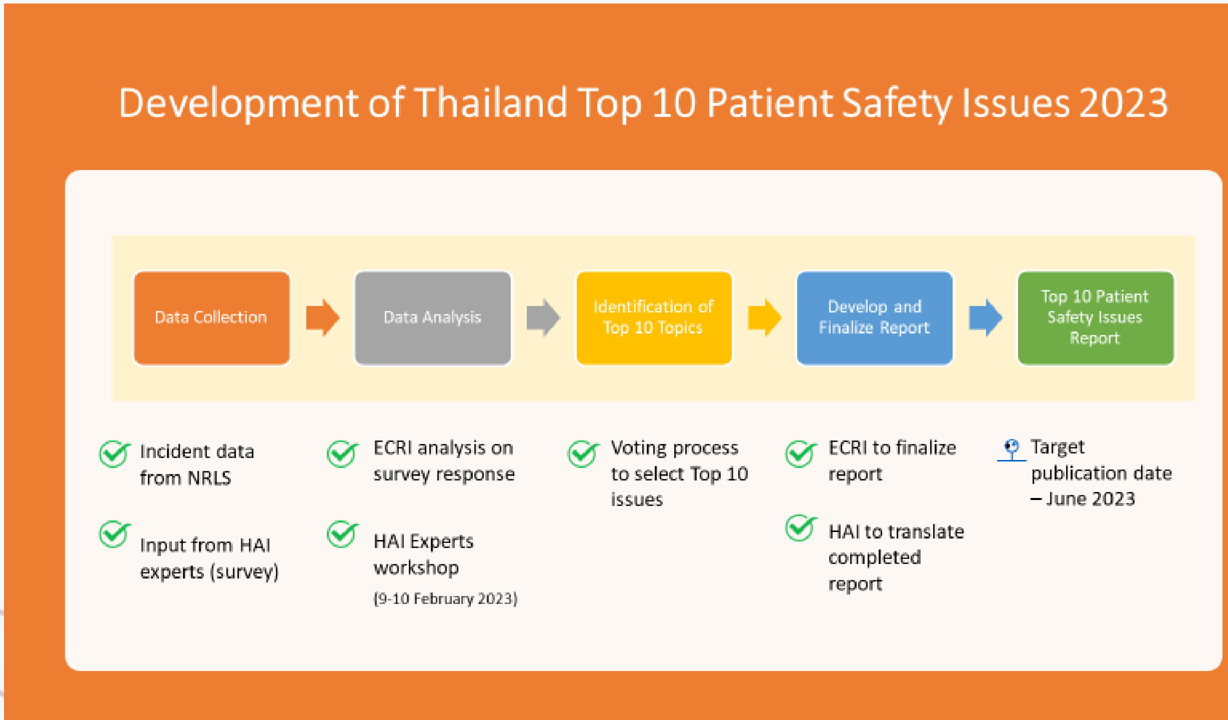
HAI & ECRI MoU Signing on 29 June 2022

Objectives:

- To identify existing and imminent patient safety challenges faced by TH hospitals
- To share lessons from ECRI and HAI's analysis of patient safety data and information
- To offer strategies to support continuous improvement
- To enable learning healthcare

MoU Objectives:

- To jointly produce a white paper on Thailand Top 10 Patient Safety Issues.
- To jointly design and hold educational seminars/ roadshows to support the local community in addressing pressing healthcare concerns.
- To jointly develop and promote the quality improvement of patient care and patient safety.



HAI Experts Workshop on 9-10 Feb 2023

Key essential standards analysed:

1. Safe Surgery
2. Infection Prevention and Control (IPC) – Patient
3. Infection and Exposure - Staff
4. Medication Error
5. Blood Safety
6. Patient Identification
7. Diagnostic Error
8. Lab-line Tube
9. Mental Health
10. Security Information
11. Maternal and Neonatal Morbidity
12. Telehealth/Telemedicine
13. AMR

For each essential standard analysed:

- Share identified key patient safety incident & survey results
- Discuss and reach consensus on contributing factors; leveraging HAI experts' knowledge and experience and ECRI's international learnings.
- Discuss guidelines/recommendations

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Voting at HA National Forum 2023

ECRI Asia Pacific

Voting Form - Thai Top 10 Patient Safety Issues

Patient Safety Issues - Contributing Factors

Additional Resources

ECRI 2023 Top 10 Health Technology Hazards

ECRI 2022 Top 10 Patient Safety Concerns

Thailand Top 10 Patient Safety Issues 2023

The 13 topics that have been nominated for consideration this year are stated in the Voting Form referenced below. Please refer to the accompanying notes on contributing factors to learn more about the 2023 safety issues.

We are asking you, and others throughout the organization, to select the 10 topics that you believe should be on the final list.

Sign in to Google to save your progress. Learn more

*Required

Please select your Top 10 Patient Safety Issue 2023 *

Safe Surgery - Wrong position, wrong side surgery, Wrong implant used during procedure

ECRI

1. SAFE SUGERY

CPS101: Wrong Position, Wrong side Surgery (Surgery or other invasive procedure performed on the wrong body part).

Wrong implant used during procedure

Contributing Factors:

- Lack of compliance to existing policies /guidelines.
- Ineffective communication (e.g., failure to involve patient during identification, failure to communicate changes/corrected information).
- Surgical site documented incorrectly during presurgical process (e.g., informed consent form, preoperative checklist).
- Emergency cases resulting in incomplete assessment of surgical site.
- Communication/transcribing error.
- Lack of presurgical planning (e.g., implant type/size, instruments required).

23rd HA National Forum

23rd HA National Forum

on14-17 March 2023 at IMPACT Forum IMPACT Exhibition and Convention Center

SYNERGY FOR SAFETY AND WELL-BEING

Final List Thailand : Top 10 Patient Safety Issues 2023

Total Votes (Round 1 + 2) : Total number of votes-2,041

Percentage breakdown

Essential Standards	1st Round of Voting	2nd Round of Voting	Total Votes	Percentage of Votes
Medication Error	1922	23	1945	95%
IPC	1872	22	1894	93%
Patient Identity	1864	23	1887	92%
Diagnostic Error	1767	23	1790	88%
Safe Surgery	1727	18	1745	85%
Infection and Exposure	1724	21	1745	85%
Laboratory/Pathology Inaccuracies	1611	20	1631	80%
Blood Safety	1603	19	1622	79%
Security Information	1594	17	1611	79%
AMR	1311	12	1323	65%
Mental Health	1254	12	1266	62%
Maternal & Neonatal	1060	16	1076	53%
Telehealth	871	4	875	43%
Total Votes	2018	23	2041	

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The Most Trusted Voice in Healthcare

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Thailand Top 10 Patient Safety Issues 2023

1. Medication Errors
2. Infection Prevention & Control
3. Patient Identification
4. Diagnostic Errors
5. Safe Surgery
6. Infection and Exposure for Healthcare
7. Laboratory/Pathology Inaccuracies
8. Blood Safety
9. Health Information Security
10. Antimicrobial Resistance (AMR)

1. Medication Errors – prescription, dispensing, administration

Contributing Factors

- Non-compliance to guideline practices (e.g., lack of independent double-checking)
- Confusion between look-alike-sound-alike drugs (e.g., inappropriate storage of LASA drugs)
- Information system (computerized provider order entry, Pharmacy Information System) design and usability issues (e.g., lack of field to enter administration route)
- Poor communication amongst clinicians and other healthcare workers results in inadequate handoffs and loss of information due to the prescription being transmitted verbally.
- Lack of patient history information may result in the wrong medication being prescribed to the patient.
- Physical environment distraction or interruptions.

Recommendations

- Medication management: separating look-alike drugs, capitalizing different letters in the names of sound-alike drugs, secure dangerous drugs by limiting access to locked areas.
- Ensure effective communication between medical staff by limiting the use of verbal or phone orders and ensuring that such orders are authenticated and signed by the ordering provider.
- Ensure effective design of computerized provider order entry (CPOE) systems, bar-coded medication administration (BCMA) systems, and automated dispensing cabinets (ADC) – to be suitable for the medical staff requirements and ease of use to limit error.
- Maintain staff awareness and provide continuing education programs for clinical staff
- Review information about medication safety risks and errors that have occurred in other organizations and take action to prevent similar errors.

Journey of Global Patient Safety

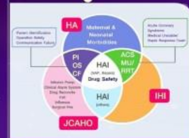
and Thailand Patient and Personnel Safety

CHANGE 2002–2021

THAILAND

2002 – 3 Steps to HA

2004 – Quality Review



2006 – 1st Patient Safety Goals

2007 – Trigger Tool to Detect Risk

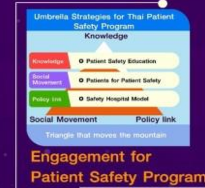
2008 – 2nd Patient Safety Goals

SIMPLE 2008
The acronyms, making them easy to memorize, of six key issues of patient that should be highlighted when promoting patient safety

2012 – Community of Practice (CoP) on High Risk Areas (ER, LR, OR, ICU)

2013 – Thailand Patient Safety Education

2014 – Thailand Patients for Patient Safety



2015 – Engagement for Patient Safety Program

2016
- Country Self-assessment for Patient Safety Situation
- Patient and Personnel (2P) Safety Policy

2017
- National Committee
- 2P Safety Strategy
- Thailand 2P Safety Day

2018
- National 2P Safety Goals
- 2p Safety Hospital
- National Reporting and Learning System
- Patient and People Participation

2019 – จัด The 1st World Patient Safety Day and the 3rd Thailand Patient and Personnel Safety Day

2020
- Essential standards for safety as the criteria for Hospital Accreditation,
- 2P Safety Tech

2021
- Patient and Personnel Safety Emerging Infection Diseases: SIMPLE2
- Community of Practice 2P Safety Learning

2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021

GLOBAL

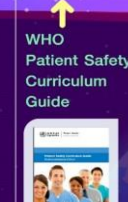
2002 – Patient Safety on the World's Agenda

2004 – The world Alliance for Patient Safety

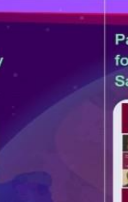
2005 – The 1st Global Patient Safety Challenge "Clean Care is Safer Care"

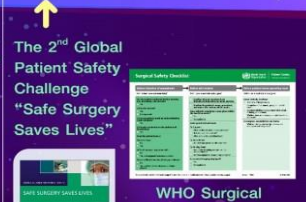
WHO Draft Guideline for Adverse Event Reporting and Learning System

2007 – The Jakarta Declaration on Patients for Patient Safety in SEAR Countries



2008 – The 2nd Global Patient Safety Challenge "Safe Surgery Saves Lives"

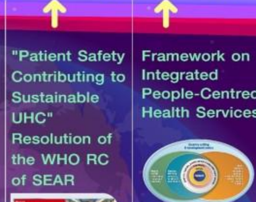




WHO Surgical Safety Checklist

2011 – WHO Patient Safety Curriculum Guide

2013 – Patients for Patient Safety



2015 – "Patient Safety Contributing to Sustainable UHC" Resolution of the WHO RC of SEAR

2016 – Framework on Integrated People-Centred Health Services

2017 – The 3rd Global Patient Safety Challenge "Medication without Harms"

2018 – "Tokyo Declaration on Patient Safety"

2019 – "Global Action on Patient Safety" Resolution of WHA (Thailand Supported)

2020 – Charter Health worker safety

2021 – Global Patient Safety Action Plan 2021–2030 "Towards eliminating avoidable harm in health care"

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Integrated Global Action Patient Safety to Thailand Action

- Propose Global Action Plan to National Patient and Personnel Safety committee.
- National survey on implementation of the Global patient safety action plan 2021–2030
- Review patient safety action and 2P safety strategy in Thailand
- Self-assessment to Identify GAP as area for improvement.
- Strategic matching to set priority
- Develop 2P safety 2022-2030 for announcement and implementation

National Patient and Personnel Safety Committee

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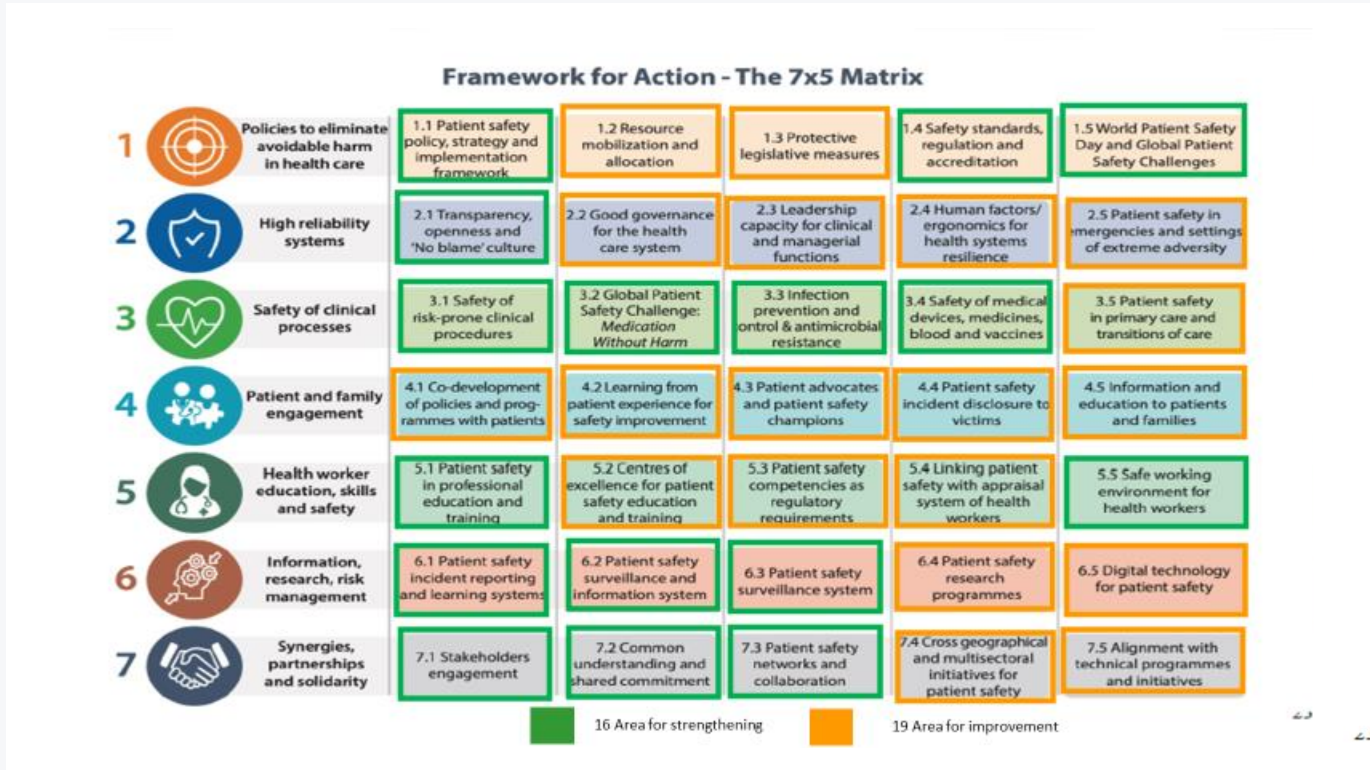
Thailand 2P Safety Strategy

Global Patient Safety Action Plan



Matching Global on Patient safety with the National Patient and Personnel Safety Strategies

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Patient Personnel and People Safety

Healthcare Systems with Quality and Safety for All 2022-2026

St.1: Prepare health personnel by enhancing their capability and raising their awareness about quality and safety

St.2: Establish collaboration with the network of civil society and the organizations involved in the healthcare system.

St.3: Develop supporting systems necessary for ensuring the quality and safety in the healthcare system.

St.4: Set up the systems for reporting, learning, and measuring the quality and safety outcomes

S5.: Increase the efficiency of the overseeing and nurturing of the healthcare system.

5

Health worker education, skills and safety

4

Patient and family engagement

7

Synergy, partnership and solidarity

3

Safety of clinical processes

6

Information, research and risk management

1

Policies to eliminate avoidable harm in health care

2

High-reliability systems

Matching Global on Patient safety with the National Patient and Personnel Safety Strategies

Hope to Strengthening 4 ST. with ECRI

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ECRI Patient Safety

Our patient safety team drives improvements in safety working with healthcare delivery organizations and stakeholders across all settings of care. Named a Patient Safety Organization (PSO) by the U.S. Department of Health and Human Services, ECRI has collected more than 3 million serious patient safety events and near-miss reports from over 1,800 healthcare providers around the country.

Who is the ECRI and How are they here with us.

BY NC SA

Piyawan Limpanyalert
11 กุมภาพันธ์ ·

..โชคดีที่มีกัลยาณมิตร..ขอบคุณที่รู้จักกัน Mr.Woo Kit Seong (Eric Woo)

..เมื่อ 5 ปีก่อนฉันมีโอกาสไปประชุมต่างประเทศเกี่ยวกับเรื่อง Quality and Safety ระหว่างพักเบรคการประชุม ได้ไปเดินชมบูธนิทรรศการที่มีการนำเสนอขององค์กรต่างๆ ฉันสนใจองค์กรที่ชื่อ ECRI (Emergency Care Research Institute) ที่มีการนำเสนองานวีจัยและข้อมูลเกี่ยวกับ Top 10 Patient Safety และทำให้ฉันได้รู้จัก Mr.Woo Kit Seong (Eric Woo) Regional Director, Asia Pacific. ECRI Institute ที่เป็นผู้นำเสนอเรื่องราวต่างๆได้อย่างน่าสนใจ สื่อสารเข้าใจง่ายและมีความเป็นมิตร ฉันเดินไปคุยกับ Woo ว่า ฉันอยากทำ Top 10 Patient Safety ของประเทศไทยบ้าง อยากเรียนรู้ว่าทำอย่างไร Woo บอกว่า ถ้ามีข้อมูล ถ้ามีทีมผู้เชี่ยวชาญที่สนใจเรื่องนี้ก็น่าจจะทำได้ แต่ต้องใช้กระบวนการวิเคราะห์ข้อมูลและการ
มีส่วนร่วม ซึ่งตอนนั้นพึ่งเริ่มพัฒนาระบบ National Reporting and Leraning System ข้อมูลยังมีไม่มาก แต่มีทีมผู้เชี่ยวชาญที่สนใจร่วมกันทำ patient and Personnel Safety Goals ฉันจึงชวนเขามารู้จักการขับเคลื่อนในประเทศไทยก่อนไหม มาสื่อสารเรื่องราวขององค์กรเขาในประเทศไทย โดยเชิญมาร่วมงาน HA national Forum ในปี 2020 ซึ่ง Woo ก็รับปาก แต่น่าเสียดายด้วยสถานการณ์โควิด ทำให้ปีนั้นไม่ได้จัดงาน แล้วเราก็ห่างหายกันไป

...ปี 2022 Mr.Dharmesh Doshi หนึ่งในทีมงานของ Woo ซึ่งเจอกันเมื่อ 5 ปีก่อนเดินทางมาเมืองไทย เพื่อขับเคลื่อนงานเรื่องเครื่องมือแพทย์และงานวิจัย ได้แวะมาหาฉันที่สำนักงาน และบอกว่า Woo ฝากถามว่ายังสนใจทำเรื่องที่เคยคุยอยู่ไหม เราน่าจะเคลื่อนร่วมกันในทางงานวิชาการหรืองานวิจัย ฉันรุ้สึกดีใจที่ Woo และทีม ERIC ยังไม่ลืมสิ่งที่ฉันตั้งใจ เราจึงเริ่มต้นคุยกันอีกครั้ง และนำมาซึ่งการลงนามความร่วมมือทางวิชาการระหว่าง สรพ.กับ ECRI เพื่อพัฒนาเชิงวิชาการมีเป้าหมาย produce a white paper on the Top 10 Patient Safety Concerns for Thailand healthcare providers through the analysis of patient safety reporting data from HAI's event reporting system, with the aim to improve patient safety through the sharing of learnings and evidence-based knowledge or information to the healthcare community. ในเดือนมิถุนายน 2565

...หลังจากลงนามความร่วมมือ เกิดการทำงานร่วมกันอย่างชัดเจน และเห็นถึงความจริงใจและตั้งใจของ Woo และทีม ที่ประชุมวาง action plan การทำงานโดยกำหนดเป้าหมายร่วมกับทีมสรพ. ทำการบ้านนำข้อมูลจาก NRLS ไปวิเคราะห์ ยกร่างประเด็นต่างๆ มานำเสนอโดยใช้ความรู้และกระบวนการที่ใช้กับการพัฒนาของ ECRI มาแลกเปลี่ยนอย่างเต็มที่ทุกครั้ง Woo เองมานั่งฟังการประชุมและการขับเคลื่อนเรื่อง 2P Safety ในประเทศทั้งวันโดยมีล่ามคอยแปลให้ เพื่อทำความเข้าใจระบบของไทย นั่นจึงเป็นที่มาที่ทำให้ฉันรู้จัก Woo มากขึ้นเรื่อยๆ และพบว่าทุกครั้งที่เจอกัน เขาพูดเสมอว่า เขาเป็น Non profit organization ที่ต้องการใช้ความรู้ในการเปลี่ยนแปลงระบบให้เกิดความปลอดภัยด้วยความไว้วางใจ อาจเป็นเพราะว่าเราคิดคล้ายกันหรือเราสนใจเรื่องเดียวกันทำให้ฉันสนิทและคุยกันลื่นไหลกับ Woo

Special Thanks for Mr.Eric Woo,
Regional Director, ECRI Asia Pacific

Thank you for your attention

Q&A

24TH HA National Forum

"ระบบบริการสุขภาพที่ก้าวหน้า ด้วยกรอบความคิดที่กว้างไกล"

การประชุมวิชาการประจำปี HA National Forum ครั้งที่ 24

12-15 มีนาคม 2567

Coming SOON