UNIVERSITÀ
DEGLI STUDI DI MILANO-BICOCCA

SYLLABUS DEL CORSO

Risk Management in Ostetricia 2

2425-2-I0102D911

Aims

At the end of the course the students will know the risk management process in the midwifery and the importance of Non Technical Skill in Healthcare

Contents

Risk Management in health is the set of various complex actions aimed to improve quality of health services and ensure patient safety based on learning from error. Human error should be considered a component of human being that cannot be eliminated ,but it's used to learn how to not repeat the same errors an same circumstances that led to the error. The Health System must implement activities to reduce the incidence of errors at various levels , to provide heathcare. Risk Management is developed in stages: error knowledge and analysis (Incident Reporting, medical records review),detection and correction of error causes (RCA,FMEA process analysis),monitoring measures to prevent the error, implementation and support of the proposed solutions. Students must be sensitized to the importance of "learning culture" .They have to learn the system approach to the study of errors

Detailed program

1. Introduction: principles of Risk Management
2. The Clinical Risk Management process
3. Aims of Clinical Risk Management policies and programs in childbirth
4. Systemic approach to error analysis
5. Tools for Clinical Risk's Operating Management
6. Voluntary reporting of adverse events: Incident Reporting System
7. Trigger collection

8. Sentinel events
9. Risk analysis methods:the Root Cause Analysis
10. Case report: RCA applied to a Near Miss
11. Training on a clinical case applying Risk analysis Tool (RCA)
12. Human Factor Analysis
13. Teamworking: organizational context influence on human performance
14. Non Tecnichal Skills (NTS): prevention methods and techniques aimed to improving security in sanitary environment

Prerequisites

none

Teaching form

Lectures; film screenings and working groups with practice using risk management tool known as Root Cause Analysis (RCA).

Textbook and teaching resource

Ministero della Salute, Linee guida per gestire e comunicare gli eventi avversi in sanità, giugno 2011

Ministero della Salute, La Sicurezza dei Pazienti e la Gestione del Rischio Clinico, Glossario, Luglio 2006

Joint Commission Resources, Eventi Sentinella, Quello che ogni organizzazione sanitaria dovrebbe sapere, C.G. Edizioni medico scientifiche, giugno 2007

Ministero della Salute, Manuale per la RCA

http://www.salute.gov.it/imgs/C_17_pubblicazioni_1103_allegato.pdf

C. Vincent, Patient safety, Esseditrice Panorama della Sanità, 2006

NHS, An organization with a memory, 2000

IOM, To err s human, 1999

J. Reason, L'errore umano, EPC, 1994

F. Novaco, V. Damen, La gestione del rischio clinico, Il Pensiero Scientifico editore, 1994

Ministero della Salute, Commissione tecnica sul rischio clinico, DM 5 marzo 2003, Risk Management in sanità – Il problema degli errori

Flin R.,O'Connor P.,Cricton M.2010 "Il front line della sicurezza-Guida alle Non Technical Skill" Hirelia Edizioni

Catino M. 2006 “Da Chernobyl a Linate.Incidenti tecnologici o errori organizzativi?-Milano-Mondadori Bruno

Semester

1-2 semester

Assessment method

attendance

Office hours

on appointment

Sustainable Development Goals

GOOD HEALTH AND WELL-BEING