

## COURSE SYLLABUS

### Risk Management in Midwifery

2526-3-I0102D908

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#### Aims

##### **Knowledge and understanding**

To acquire in-depth knowledge of the clinical risk management process in Obstetrics, with particular attention to the approaches and methodologies used to ensure safety in obstetric practice. To understand the concepts and techniques related to the development of non-technical skills (NTS) in the healthcare context.

##### **Applying knowledge and understanding**

To apply the acquired knowledge of clinical risk management in daily obstetric practice, using appropriate methodologies to identify, prevent, and manage potential risks. To develop and apply non-technical skills (NTS) to optimize the management of critical situations and improve communication and teamwork in healthcare settings.

##### **Making judgements**

To develop the ability to autonomously assess clinical risks in Obstetrics and make timely and effective decisions to mitigate those risks. To recognize the need to enhance non-technical skills (NTS) in various situations and apply evidence-based approaches to improve the quality of care.

##### **Communication skills**

To develop communication skills to foster effective collaboration among healthcare team members, managing communication in high-risk and stressful situations. To use non-technical skills (NTS) to enhance dialogue and coordination during critical obstetric scenarios.

##### **Learning skills**

To adopt a continuous learning approach to update knowledge on clinical risk management in Obstetrics and the development of non-technical skills (NTS), actively participating in training courses, simulations, and research.

#### 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 in same circumstances that led to the error. The Health System must implement activities to reduce the incidence of errors at various levels, to provide healthcare. 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 Technical 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](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 is 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., Crichton 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 | QUALITY EDUCATION | PARTNERSHIPS FOR THE GOALS

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