FOR AN EUROPEAN ACCREDITED SPECIALIST DOCTOR
Introduction to the Training Standards

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Presidente OMCeO Nuoro

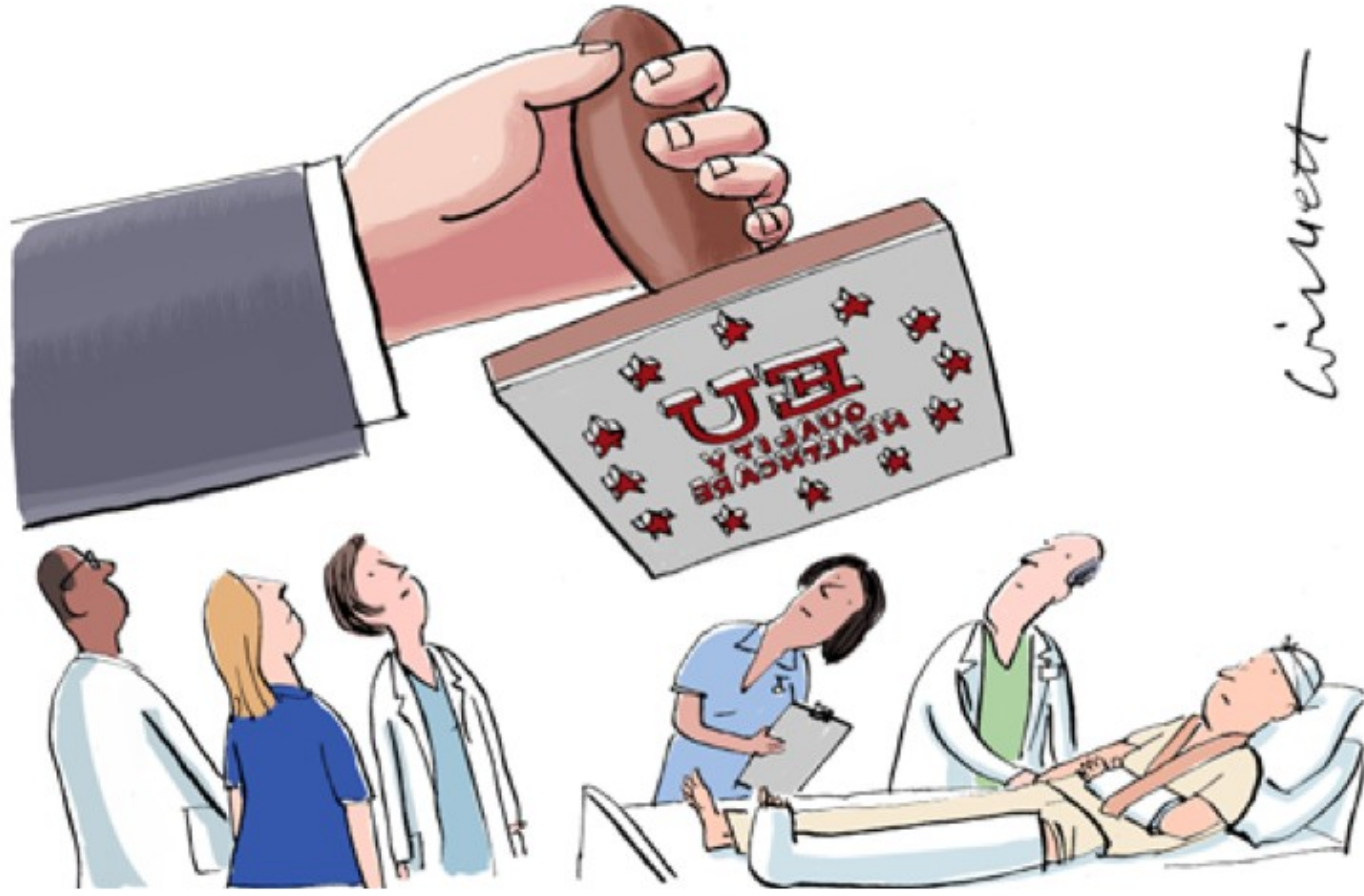**Coordinatore centro Studi Nazionale FNOMCeo**

UDINE PALAZZO BELGRADO Piazza Patriarcato, 3

9-10 September 2011

Libera circolazione dei cittadini e dei professionisti

E possibile uno standard formativo e valutativo comune degli specialisti europei?
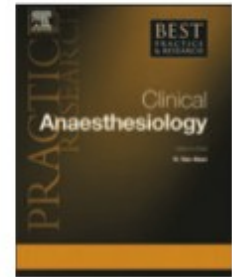
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How do we know that we are doing a good job – Can we measure the quality of our work?

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Joint Commission : Sentinel events

Most Frequently Identified Root Causes of Sentinel Events Reviewed by The Joint Commission by Year

The majority of events have multiple root causes
(Please refer to subcategories listed on slides 5-7)

2008 (N=927)		2009 (N=936)		2010 (N=802)	
Assessment	465	Assessment	602	Leadership	710
Care Planning	83	Care Planning	136	Human Factors	699
Communication	510	Communication	612	Communication	661
Continuum of Care	96	Continuum of Care	97	Assessment	555
Human Factors	453	Human Factors	614	Physical Environment	284
Information Management	209	Information Management	250	Information Management	226
Leadership	510	Leadership	653	Operative Care	160
Medication Use	81	Medication Use	83	Care Planning	135
Operative Care	113	Operative Care	138	Continuum of Care	112
Physical Environment	185	Physical Environment	237	Medication Use	86

The Joint Commission

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these root cause data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of root causes or trends in root causes over time.

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TO ERR IS HUMAN
Building a Safer Health System

Linda T. Kohn, Janet M. Corrigan, and
Molla S. Donaldson, *Editors*

Committee on Quality of Health Care in America

INSTITUTE OF MEDICINE

NATIONAL ACADEMY PRESS
Washington, D.C.

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Setting Performance Standards and Expectations for Patient Safety

The development and availability of standards for patient safety can serve several purposes. They can either establish minimum levels of performance or can establish consistency or uniformity across multiple individuals and organizations. Another purpose for standards is that they set expectations. The process of developing standards can set expectations for the organizations and health professionals affected by the standards. The publication and dissemination of standards additionally helps to set expectations for consumers and purchasers.

Standards can be developed and used in public regulatory processes, such as licensure for health professionals and licensure for health care organizations, such as hospitals or health plans. Standards can also be developed through private voluntary processes, such as professional certification or organizational accreditation.

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- **RECOMMENDATION 7.2 Performance standards and expectations for health professionals should focus greater attention on patient safety.**

- **• Health professional licensing bodies should**

- **(1***) implement periodic reexaminations and relicensing of doctors, nurses, and other key providers, based on both competence and knowledge of safety practices; and*
(2) work with certifying and credentialing organizations to develop more effective methods to identify unsafe providers and take action.

- **• Professional societies should make a visible commitment to patient safety by establishing a permanent committee dedicated to safety improvement. This committee should develop a curriculum on patient safety and encourage its adoption into training and certification requirements; disseminate information on patient safety to members at special sessions at annual conferences, journal articles and editorials, newsletters, publications and websites on a regular basis**

- **(3)** *recognize patient safety considerations in practice guidelines and in standards related to the introduction and diffusion of new technologies, therapies, and drugs*;
(4) work with the Center for Patient Safety to develop community-based, collaborative initiatives for error reporting and analysis and implementation of patient safety improvements; and

- **(5) collaborate with other professional societies and disciplines in a national summit on the professional's role in patient safety.**

Health care has much to learn from other industries about improving safety

HOW OTHER INDUSTRIES HAVE BECOME SAFER ?

- *The risk of dying in a domestic jet flight between 1967 and 1976 was 1 in 2 million. By the 1990s, the risk had declined to 1 in 8 million. Between 1970 (when the Occupational Health and Safety Administration was created) and 1996, the workplace death rate was cut in half.* **Health care has much to learn from other industries about improving safety.**

CHEST (2009; 136:910–917)

What Went Right

Lessons for the Intensivist From the Crew of US Airways Flight 1549

Lewis A. Eisen, MD, FCCP; and Richard H. Savel, MD

On January 15, 2009, US Airways Flight 1549 hit geese shortly after takeoff from LaGuardia Airport in New York City. Both engines lost power, and the crew quickly decided that the best action was an emergency landing in the Hudson River. Due to the crew's excellent performance, all 155 people aboard the flight survived. Intensivists can learn valuable lessons from the processes and outcome of this incident, including the importance of simulation training and checklists. By learning from the aviation industry, the intensivist can apply principles of crew resource management to reduce errors and improve patient safety. Additionally, by studying the impact of the mandated process-engineering applications within commercial aviation, intensivists and health-care systems can learn certain principles that, if adequately and thoughtfully applied, may seriously improve the art and science of health-care delivery at the bedside.

(CHEST 2009; 136:910–917)

Abbreviations: CRM = crew resource management; FAA = Federal Aviation Administration; NTSB = National Transportation Safety Board

CHEST (2009; 136:910–917)

- On January 15, 2009, US Airways Flight 1549 hit geese shortly after takeoff from LaGuardia Airport (New York, NY), causing both engines to lose power. The first officer was controlling the aircraft. Captain Chesley Sullenberger took over control of the airplane and radio communications, **and _instructed the first officer to run an engine restart checklist, which was unsuccessful_**. Without engine power, Sullenberger determined that he was unable to reach either LaGuardia or Teterboro airport in New Jersey. **_The flight crew decided that an emergency landing in the Hudson River was necessary_** (Fig 1). Due to **_expert crew performance_** (Table 1), all 155 people aboard survived the 5-min flight (Table 2).1,2

..on a cockpit simulator…..

- Both the captain and the first officer of Flight 1549 had logged many hours *on a cockpit simulator* of the Airbus 320 aircraft they were piloting. They had practiced standard flights as well as emergency scenarios. *Sullenberger had never experienced an engine failure in an actual flight, but he had experienced it on the flight simulator.*

CHEST (2009; 136:910–917)

CHEST (2009; 136:910–917)

- Establish a national focus to enhance the knowledge base about safety

- Develop a **mandatory error-reporting** system and encourage healthcare practitioners to develop and participate in voluntary reporting systems

- ***Raise performance standards*** through the actions of oversight organizations, **professional groups**, and group purchasers of health care

- Implement safety systems in health-care organizations to ensure safe practices, **including simulation**

"To Err is Human." NAP 1999

CHEST (2009; 136:910–917)

- In many respects, *medical training is less regimented. Medical personnel learn on the job about how to handle novel emergencies.* A team may respond to cardiac arrest and use a defibrillator model that they have never encountered. The requirements for recurrent evaluation are considerably less rigorous as well*. Because learned skills atrophy over time, medical practitioners, like pilots, can benefit from frequent training and evaluation on simulators*. Medical practitioners could be tested on simulations germane to their particular medical specialty as the American Board of Internal Medicine does for interventional cardiology.

CHEST (2009; 136:910–917)

- An article by Martin et al, coauthored by Captain Sullenberger, reviewed the factors associated with major airplane accidents. A common decisional error the authors identified is called **"plan continuation error"** (an example of a **fixation error**). Pilots involved in major accidents often failed to consider all available options and would persist in their original plan when unexpected threats arose. In CRM training, pilots are instructed to project the likelihood of the success of various options and consider the disadvantages of a particular plan before implementing it.

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