

Costs of the risk and how to reduce or eliminate the risk

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Another important factor in clinical risk management

Health Care Professionals

- are they competent?**
- are they practicing beyond their level of experience and skill?**
- are they suffering from stress or illness?**

Fitness-to-practise requirements

All health professionals are accountable for their actions and conduct in the health service provision environment.

They are responsible for their actions according to each circumstance they find themselves.

Accountability  Fitness-to-practice

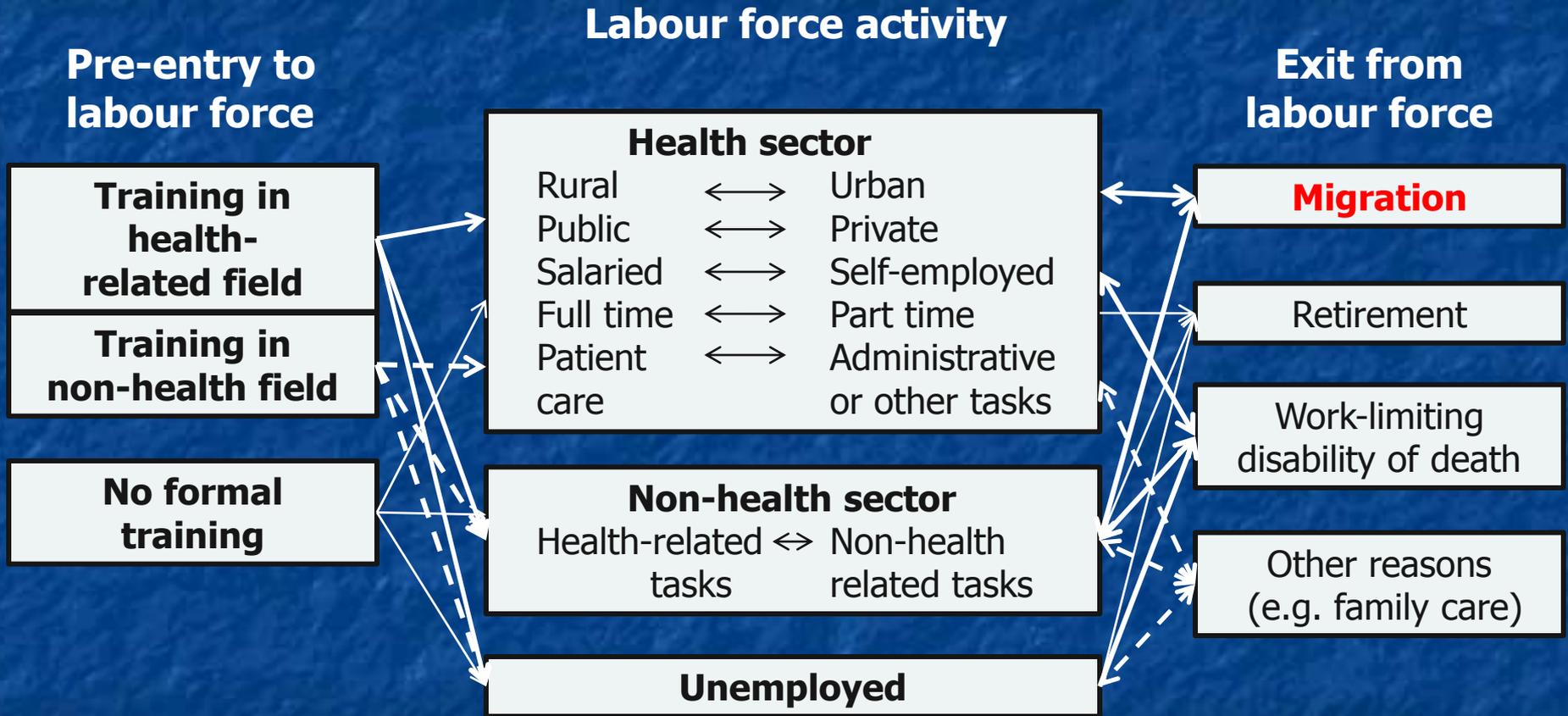
Who are the health workers?

The World Health Organization defines the health workforce as “all people engaged in actions whose primary intent is to enhance health” (*WHO, The world health report 2006: working together for health*)

WHO Framework for defining the health workforce

Individual's training, occupation, place of work	Working in health industry	Working in non-health industry or inactive
Training in health and employed in health occupation	E.g. MDs, nurses, midwives, physiotherapists working in health-care facilities	E.g. MDs working in pharmaceutical industry, private nurses, pharmacists
Training in health but not employed in health occupation	E.g. medically trained managers of health-care facilities	E.g. medically trained academic staff
Training in a non-health field or no formal training	E.g. economists, IT specialists, chemists, physicists, , cleaning staff, Roma health mediators	

HRH active life and associated training programmes



Health education programmes offered by accredited institutions (universities)

CME programmes
New competencies

Brain / competence drain

How to make health practitioners fit to practice

- **certification and licensing**
- **credentialing**
- **accreditation**
- **in-migration of trained health workers from other countries (procedures for competence recognition)**

Certification and licensing

The main purpose of certification and licensing is to protect the health and safety of the public through mechanisms designed to ensure that health practitioners are fit to practice.

Certification and licensing purposefully weed out unqualified health workers, those whose knowledge and skills do not match the minimal requirements for their professional regulations or occupational standard.

Certification and licensing

For certain cadres, usually less qualified, quality at the level of the individual health worker is controlled by graduating from an accredited training institution – CERTIFICATION

Certification to practice a profession most often does not need to be renewed periodically.

Certification and licensing

For highly-educated cadres, the licensing requirements include most often to pass a professional qualification exam (for MDs – specialty training graduation exam).

Most countries require health-care practitioners to be registered with a government authority or under a government instrument, such as the College/Chamber of Physicians, Order of Nurses, granting the license to practice.

Certification and licensing

The license to practice most often needs to be periodically renewed based on different criteria such as: passing a renewal exam, demonstrating participation in continuing medical education programmes, being employed in the field or simply paying a fee.

Licensing procedures in Romania

The licensing process for MDs is performed by the College of Physicians from Romania based on the compliance of:

- holding Romanian citizenship;**
- being husband/wife, daughter/son of a Romanian citizen;**
- being permanent residents in Romania;**
- have previously obtained the recognition of official qualification title;**
- are medically able for performing the activity;**
- membership of the RCP should be annually renewed based on the malpraxis insurance and a certain number of CME credits.**

Licensing procedures in Romania

The licensing process for medical nurses is performed by the Romanian Order of Medical Nurses and Midwives based on the compliance of:

- holding Romanian citizenship;**
- being husband/wife, daughter/son of a Romanian citizen;**
- being permanent residents in Romania;**
- have previously obtained the recognition of official qualification title;**
- membership of the OMNMP should be annually renewed based on the malpraxis insurance and a certain number of CME credits.**

Credentialing

The Australian Council on Healthcare Standards defines credentialing as the process of assessing and conferring approval on a person's suitability to provide specific consumer/patient care and treatment services, within defined limits, based on an individual's license, education, training, experience, and competence.

Accreditation

Accreditation is a formal process to ensure delivery of safe, high-quality health care based on standards and processes devised and developed by health-care professionals for health-care services.

Health workforce migration

SEEHN countries are at present mainly source countries for health professionals flows.

On one hand, this situation is the result of European Union (EU) enlargement in 2007 (Romania and Bulgaria) and 2013 (Croatia), but on the other hand, some dynamics related to poor planning and management of the health workforce or traditional migration in Balkans' countries can be also involved.

Health workforce migration

SEEHN countries are at present mainly SOURCE countries for health professionals flows, most frequently toward EU.

The EU funded project PROMETHEUS (<http://www.euro.who.int/en/about-us/partners/observatory/activities/research-studies-and-projects/prometheus>) found that there are NO monitoring systems in place for the mobility of the health workforce in SEE countries (Romania and Serbia participated).

Health workforce migration – example of Romania

The verification certificates (certificates to attest the university studies and specialty training in Romania for health professionals according to DC 2005/36/CE) issued by the Ministry of Health since 2007 and the certificates of good standing (to attest the ethical professional behavior) issued by the Romanian College of Physicians since 2008 provide some data on out-migration of health professionals, but Romania has no accurate information on international inflows and outflows of health professionals.

Health workforce migration – example of Romania (MDs)

The estimation of the outmigration rate can be calculated based on the number of CGSs issued by RCP per year. Destination countries request CGSs for registering procedures and therefore they indicate only the intention to leave and not actual emigration.

Outmigration rate of the Romanian MDs, 2008 – 2012

<i>Issuing year</i>	<i>No. of practicing MDs</i>	<i>No. of CGS applications</i>	<i>%</i>
2008	50267	1155	2.29
2009	50386	1397	2.77
2010	52204	2797	5.35
2011	52541	2804	5.33
2012	Not published yet	2217	
Total		10370	

Source: Romanian College of Physicians data warehouse

Health workforce migration – example of Romania (MDs)

France, Germany, Italy and UK seem to be the most favorite destination countries, mainly due to their active recruiting policies from other countries. The most demanded medical specialties are: family medicine, intensive care, neurology, neurosurgery and psychiatry.

Annual loss of MDs in the health system is estimated at a value between 10% and 30%, including both the emigrating personnel and personnel leaving the health system for another sector.

Health workforce migration – example of Romania (MDs)

There are no public data on foreign MDs working in Romania. The RCP is not recording in its national database the citizenship of the MDs or their place of birth. At district level, there are paper copies of the birth certificates and ID cards so that it might be possible to retrieve the information on immigration flows.

Nevertheless, a new phenomenon occurred in the Romanian health system: INFLOW OF FOREIGN BORN MDs.

Health workforce migration – example of Romania (MDs)

2 types of immigration flows:

- long-term immigration (Moldovan MDs)**
- Cross-border migration (MDs from Bulgaria and Hungary)**

MDs from Bulgaria are working in Romanian hospitals across the Danube river (e.g. 4 out of 5 intensive care specialists in a Romanian hospital are from Bulgaria) and there is an exchange of MDs across the border with Hungary (Arad and Bihor districts)

Health workforce migration – example of Romania (nurses)

The nurses' emigration phenomenon is almost unknown (not all the EU countries are requesting a recognition certificate). Even the number of certificates issued by the MoH and the Medical Nurses and Midwives Order do not estimate in any way the intention to leave.

Starting with January 2007, the MoH is issuing a certificate for diploma recognition to the nurses and midwives at their request

- in 2007 2896 requests**
- in 2008 1977 requests**
- in 2009 (January-April) 612 requests**

Health workforce migration – diploma recognition procedures in Romania

Professional practice (for both MDs and nurses) is regulated by law (Law 85/2006).

Rules of practice are different for Romanian and EU citizens from the citizens of third-party countries.

Recognition of medical diploma and specialties is done by the MoEd institution, the National Centre for Recognition and Equivalence of Diplomas, responsible for Directive 2005/36/EC implementation, based on a certificate from the MoH confirming the compliance of specialties in case of similar profile, length and content of studies.

Health workforce migration – diploma recognition procedures in Romania for non-EU citizens

- 1. compliance to the citizenship conditions
(Romanian citizenship or family relationships)**
- 2. recognition of diploma and specialization
(NCRED, after 2007 all non-EU citizens should
attend the whole specialty training programme
in Romania, participating at the national
specialty training contest, like Romanian
graduates)**
- 3. get the membership of the RCP (license),
annually reconfirmed**

Health workforce migration – diploma recognition procedures in Romania for EU citizens

- 1. compliance to the citizenship conditions
(EU citizenship)**
- 2. recognition of diploma and specialization
(NCRED and the MoH)**
- 3. get the membership of the RCP (license),
annually reconfirmed**

Health workforce migration – example of Serbia (MDs)

Serbia – a SOURCE country for health professional mobility (especially cross-border out-flows)

According to the Census 2002:

- Since 1960, the total number of Serbian health professionals working abroad was 10,000; most popular destinations Germany (28%) and Switzerland (15%).**
- in 2008 there were 341 Serbian MDs practicing in Slovenia**

Health workforce migration – example of Serbia (MDs)

- **lack of robust data concerning health professionals mobility**
- **3 patterns of health professionals mobility:**
 - **1960-1989 (mainly toward West Europe)**
 - **1990-1999 political instability created a new wave of emigration (>30000 highly educated people left Serbia and Montenegro)**
 - **after 2000 mainly toward Germany, but also neighboring countries (Slovenia and Croatia)**

Health workforce migration – example of Serbia (MDs)

- **general health professional emigration remains at relatively low levels in Serbia (a total of 1300 to 1700 recognition certificates were issued over a 10-year period (2000–2010))**
- **there is an overproduction of MDs**
- **there is no evidence that EU enlargement in 2004 and 2007 affected health professionals mobility in Serbia**
- **Serbian citizens are required to pass the recognition / equivalence assessment procedures**

Professional certification/licensure, accreditation alone can document the quality of health workers, but do not necessarily reflect the quality of care they provide.

Quality of service provision is affected by many other factors, such as:

- workload (fatigue)**
- motivation**
- supervision**
- available resources (e.g. equipment, supplies, support staff)**
- lifelong learning.**

Important developments in South Eastern Europe

Covering 7 West-Balkans countries:
Albania, Bosnia and Herzegovina, Croatia,
Kosovo, Montenegro, Serbia and
The Former Yugoslav Republic of Macedonia

**SEE2020
Growth
Strategy**

under the auspices
of
Regional
Cooperation
Council (RCC)



Important developments in South Eastern Europe

SEE2020 Strategy Inclusive Growth

skills development, employment creation and labour market participation by all, including vulnerable groups and minorities

PILLAR 1

Scale up Implementation of Universal **Primary Care**
Develop a Regional Model for Improved delivery of Prevention & Health Promotion Programs & Services

PILLAR 2

Strengthen **intersectoral governance** for health
Adopt a regional information exchange for capacity building on improving Health & Fair Development

PILLAR 3

Harmonise **cross border public health standards, legislation and services**
Foster cross border cooperation and free trade area from PH perspective

PILLAR 4

Strengthen **Human Resources for Health** & Monitor Human Resource Migration/Mobility
Harmonise professional standards & Qualifications

**Lifelong learning – where to
introduce patient safety issues**

Labour force activity

Pre-entry to labour force

Training in health-related field

Training in non-health field

No formal training

Health sector
Rural ↔ Urban
Public ↔ Private
Salaried ↔ Self-employed
Full time ↔ Part time
Patient care ↔ Administrative or other tasks

Non-health sector
Health-related tasks ↔ Non-health related tasks

Unemployed

Exit from labour force

Migration

Retirement

Work-limiting disability or death

Other reasons (e.g. family care)



Different training/research priorities in different countries

Developing countries	Countries in transition	Developed countries
Strong emphasis on applied and evaluative research leading to the development of local cost-effective solutions		
1. Counterfeit & substandard drugs	Inadequate competencies & skills	Lack of communication & coordination (including coordination across organizations, discontinuity & handovers)
2. Inadequate competencies & skills	Lack of appropriate knowledge & transfer	Latent organizational failures
3. Maternal & newborn care	Lack of communication & coordination (including coordination across organizations, discontinuity & handovers	Poor safety culture & blame-oriented processes
4. Health care-associated infection	Health care-associated infection	Inadequate safety indicators
5. Unsafe injection practices	Maternal and newborn care	Adverse drug events due to drugs & medication errors
6. Unsafe blood practices	Adverse events due to drugs & medication errors	Care or the frail & elderly

How to define specific training programmes

Topic	Research Question
Counterfeit and substandard drugs	<p>How effective are regulatory actions and interventions in addressing this issue?</p> <p>How much do counterfeit and substandard drugs contribute to the problems of patient safety?</p> <p>What are the factors that lead to the use of counterfeit and substandard drugs?</p>
Inadequate competence training and skills	<p>Are health-care professionals adequately trained in assessing and dealing with patients with reported adverse events or medical errors?</p> <p>Is patient safety a specific topic in the core curricula of physicians, nurses and health managers?</p> <p>What kind of continuing medical education programmes are most effective for ensuring that physicians and nurses retain competency in patient safety?</p>
Maternal and newborn care	<p>What are the main safety issues in maternal and newborn care?</p> <p>What is the burden of unsafe maternal and newborn care?</p> <p>What are the most cost-effective strategies for improving the safety of maternal and newborn care?</p> <p>What resources and systems are needed to implement recommended maternal and newborn care interventions effectively?</p>
Health care-associated infections	<p>What are the epidemiology of and risk factors for health care-associated infections in hospitals?</p> <p>What is the availability and cost of commercial handrub products and how does that affect hand hygiene promotion strategies?</p> <p>What strategies are effective in optimizing participation in infection control practices?</p> <p>Are there effective plans in place for the control of epidemic outbreaks of health care-associated infections?</p> <p>Does use of new practices (e.g. silver-coated catheters) reduce the incidence of health care-associated infections?</p>

4 steps to define Patient Safety training curricula

- 1. Assessing training needs (methods: surveys, stakeholders interviews, focus groups; duration of training; target audience; available resources; local context)**
- 2. Setting educational goals / objectives / outcomes (based on competencies' needs)**
- 3. Designing a training programme (e.g. postgraduate programme; one/two days workshops; distance learning programmes; Master programme; CME programmes)**
- 4. Evaluation (written tests; project writing; direct observation of performance)**

Core competencies for Patient Safety as defined by WHO

1. The fundamental concepts of the science of patient safety in their specific social, cultural and economic context

1.1 Basic definitions and foundational concepts, including human factors and organizational theory

1.2 The burden of unsafe care

1.3 The importance of a culture of safety

1.4 The importance of effective communication and collaboration in care delivery teams

1.5 The use of evidence-based strategies for improving the quality and safety of care

1.6 The identification and management of hazards and risks

1.7 The importance of creating environments for safe care

1.8 The importance of educating and empowering patients to be partners for safer care

Core competencies for Patient Safety as defined by WHO

2. How to design and conduct patient safety research

2.1 Search, appraise and synthesize the existing research evidence

2.2 Involve patients and carers in the research process starting with defining research objectives

2.3 Identity research questions that address important knowledge gaps

2.4 Select an appropriate qualitative or quantitative study design to answer the research questions

2.5 Conduct research using a systematic approach, valid methodologies and information technology

2.6 Employ valid and reliable data measurement and data analysis techniques

2.7 Foster interdisciplinary research teams and supportive environments for research

2.8 Write a grant proposal / Obtain research funding

2.9 Manage research projects

2.10 Write up research findings and disseminate key messages

2.11 Evaluate the impact of interventions as well as feasibility and resource requirements

2.12 Identity and evaluate indicators of patient safety for use in monitoring and surveillance

Core competencies for Patient Safety as defined by WHO

3. Be part of the process of translating research evidence to improve the safe care of patients

3.1 Appraise and adapt research evidence to specific social, cultural and economic contexts

3.2 Use research evidence to advocate for patient safety

3.3 Define goals and priorities for making health care safer

3.4 Translate research evidence into policies and practices that reduce harm

3.5 Partner with key stakeholders in overcoming barriers to change

3.6 Promote standards and legal frameworks to improve safety

3.7 Institutionalize changes to build supportive systems for safer care

3.8 Apply financial information for knowledge translation

3.9 Promote leadership, teaching and safety skills

WHO developed an online Introductory course for Patient Safety Research in 4 languages (English, French, Spanish and Portuguese)

Recording and slides are available at:

http://www.who.int/patientsafety/research/online_course/en/index.html

Conclusions

All health-care professionals should:

- **Be responsible for their patients – not just the seniors**
- **Be personally accountable to prevent harm**
- **Identify areas prone to errors**
- **Work to maintain a safe clinical working environment by developing necessary skills to create a safe environment for patients and colleagues**

Thank you!

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