## Programme

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker(s)</th>
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</thead>
<tbody>
<tr>
<td>09:00</td>
<td>Registration / tea &amp; coffee</td>
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<tr>
<td>09:30</td>
<td><strong>Introduction &amp; presidents welcome</strong></td>
<td>Dr Kathleen Ferguson, President, Association of Anaesthetists &amp; Prof Ravi Mahajan, President, RCoA</td>
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<tr>
<td>09:40</td>
<td><strong>Keynote address - Developing a New Strategy for Patient Safety in England</strong></td>
<td>Dr Aidan Fowler, NHS National Director for Patient Safety</td>
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<tr>
<td>10:05</td>
<td>How tiredness affects work performance</td>
<td>Dr Nancy Redfern, Newcastle</td>
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<tr>
<td>10:30</td>
<td>Penicillin – the de-labelling challenge</td>
<td>Dr Louise Savic, Leeds</td>
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<tr>
<td>10:55</td>
<td><strong>Tea &amp; coffee / poster viewing</strong></td>
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<tr>
<td>11:25</td>
<td><strong>Capnography: no trace, wrong place</strong></td>
<td>Prof Jonathan Hardman, Nottingham</td>
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<tr>
<td>11:50</td>
<td><strong>Mathematical modelling of drug error: implications for safety interventions</strong></td>
<td>Prof Jaideep Pandit, Oxford</td>
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<tr>
<td>12:15</td>
<td>What’s dropped through your (electronic) mailbox?</td>
<td>Dr Mike Nathanson, Nottingham</td>
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<tr>
<td>12:40</td>
<td><strong>Lunch / poster viewing</strong></td>
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<tr>
<td>13:40</td>
<td><strong>Checklists: are they all they’re cracked up to be?</strong></td>
<td>Dr Tim Meek, Middlesbrough</td>
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<tr>
<td>14:05</td>
<td><strong>DPSIMS: the future of patient safety incident recording and learning</strong></td>
<td>Ms Lucie Musset, Patient Safety Lead for the Development of the Patient Safety Incident Management System (DPSIMS)</td>
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<tr>
<td>14:30</td>
<td><strong>Equipment standards (and sausage dogs)</strong></td>
<td>Dr Harvey Livingstone, Liverpool</td>
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<tr>
<td>14:55</td>
<td><strong>Tea &amp; coffee / poster viewing</strong></td>
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<tr>
<td>15:20</td>
<td><strong>Forcing error – driving innovation</strong></td>
<td>Dr Peter Young, King’s Lynn</td>
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<td>15:45</td>
<td><strong>Safety II: the safety of everyday clinical work</strong></td>
<td>Dr Alastair Ross, Glasgow</td>
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<td>16:10</td>
<td><strong>Oral presentations and winner presentations</strong></td>
<td>Dr Craig Bailey, Chair of Safety Committee, Association of Anaesthetists</td>
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<td>16:45</td>
<td><strong>Close of Meeting</strong></td>
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Learning Objectives

Keynote address - Developing a New Strategy for Patient Safety in England Dr Aidan Fowler, NHS National Director for Patient Safety
1. Opportunity to understand the direction of travel for Public Safety in England and how the system works.

How tiredness affects work performance Dr Nancy Redfern, Newcastle
1. To understand some of the impacts tiredness has on our performance at work.
2. To review ways of mitigating this in our own departments.
3. To consider how we might change organisational culture so the NHS adopts effective fatigue risk management strategies amongst its night workers.

Penicillin – the de-labelling challenge Dr Louise Savic, Leeds
1. Understanding the scale of the problem of penicillin allergy labels.
2. Understanding the harm that these can cause.
3. Understanding ways in which testing might be simplified/streamlined.
4. Understanding the role anaesthetists might play in penicillin allergy ‘de-labelling’ patients.

Capnography: no trace, wrong place Prof Jonathan Hardman, Nottingham
1. To understand the physiology underlying capnography.
2. To understand the effect of disturbed circulation, ventilation and airway placement on capnography.
3. To recognise the significance of altered capnography in circulatory arrest.
4. To appreciate the causes of absent (or grossly abnormal) capnography.
5. To be able to apply recommendations regarding the use of capnography in avoiding airway complications.

Mathematical modelling of drug error: implications for safety interventions Prof Jaideep Pandit, Oxford
1. Never Events are randomly distributed.
2. Mathematical modelling helps us understand how error arises.

What’s dropped through your (electronic) mailbox? Dr Mike Nathanson, Nottingham
1. The role of guidelines and other Association publications
2. Quality control of guidelines
3. Going digital

Checklists: are they all they’re cracked up to be? Dr Tim Meek, Middlesbrough
1. To provide a critical appraisal of the negative aspects of checklists.
2. To apply a brake, where necessary, on checklist related enthusiasm.
3. To highlight aspects of checklist ‘best practice’.

DPSIMS: the future of patient safety incident recording and learning Ms Lucie Musset, Patient Safety Lead for the Development of the Patient Safety Incident Management System (DPSIMS)
1. To understand the context and scope of the new national Patient Safety Incident Management System.
2. To get up-to-date with progress on this project.
3. To understand how to feed back to the project to share your expertise.

Equipment standards (and sausage dogs) Dr Harvey Livingstone, Liverpool
1. Understanding of what is an equipment standard.
2. How equipment standards are relevant to health care professionals.
3. Equipment safety.

Forcing error – driving innovation Dr Peter Young, King’s Lynn
1. The limitations of checklists.
2. Human error.

Safety II: the safety of everyday clinical work Dr Alastair Ross, Glasgow
1. Be familiar with the potential benefit of Human Factors applied to Patient Safety
2. Have knowledge of the scientific discipline of Resilient Health Care
3. Be able to critically appraise ‘Safety I’ and ‘Safety II’

Domain 1: Knowledge, skills & performance
Domain 2: Safety & quality
Domain 3: Communication, partnership & teamwork
Domain 4: Maintaining Trust