Improving patient safety

Tuesday 20 March 2018
Organiser: Drs Matt Hill & David Viira, Plymouth

Programme

09:20	**Registration and coffee**
09:45	**Welcome** Drs Matt Hill & David Viira, Plymouth
10:00	**Rethinking patient safety 1I01, 1I03, 1I05** Dr Suzette Woodward, National Campaign Director for Sign up to Safety Campaign
10:45	**Playing in the sandpit – behaviours in the workplace 1I01, 1I03, 1I05** Dr Neil Spenceley, Glasglow
11:30	**How fatigue affects performanace s 1I02, 1I03** Dr Nancy Redfern, Newcastle-Upon-Tyne
12:15	**Discussion**
12:30	**Lunch**
13:30	**Wrong Site Interventions review – the Healthcare Safety Investigaction Branch 1I01, 1I02,1I03, 1I04, 1I05** Ms Sandy Lewis, Healthcare Safety Investigation Branch
14:15	**Understanding complexity of the perioperative environment1I02, 1I03, 1I05** Dr Danielle Franklin, Plymouth
15:00	**Learning from excellence – how to do it 1I02, 1I03, 1I05** Dr Gemma Crossingham, Plymouth
15:45	**Discussion**
16:00	**Depart**

This seminar covers the following domains of the General Medical Council's 'Good Medical Practice' framework;

Domain 2: Safety and quality
Domain 3: Communication, partnership and teamwork

Learning objectives

The knowledge of factors that influence the safe delivery of care continues to evolve, and the day will consider the national landscape and locally implemented projects that are contributing to the improvement. This day will look at the how the emerging theories have been transferred into practice and have been used to improve the safety of the care that we deliver to our patients. The expert faculty will give practical examples of they have transferred the theory into practice and the barriers that they have faced and potential pitfalls to be avoided. We hope that the day will give the knowledge and inspiration for attendees to take back ideas and implement them in their own hospital

1. To understand the national context of patient safety
2. Understand the critical effect that our behaviour and fatigue has on team performance and individual functioning
3. To improve our understanding of emerging factors important to patient safety
4. To understand the role of the Healthcare Safety Investigation Branch in improving safety
5. Knowledge and understanding and of Safety 2 (how we get things right) and Learning form Excellence and how to start it