Patient safety conference 2018 - Safe Anaesthesia Liaison Group (SALG) - Thursday 22 November 2018

Organisers: Drs Craig Bailey, Kathleen Ferguson and Tim Meek, Safe Anaesthesia Liaison Group

Location: Civic Centre Barras Bridge, Newcastle upon Tyne

Programme

09:00 Registration / tea & coffee

09:30 **Introduction & presidents welcome**
Dr Kathleen Ferguson, President, Association of Anaesthetists & Prof Ravi Mahajan, President, RcoA

Chaired by Dr Tim Meek

09:40 **Keynote address - Developing a New Strategy for Patient Safety in England**
Dr Aidan Fowler, NHS National Director for Patient Safety

10:05 **How tiredness affects work performance**
Dr Nancy Redfern, Newcastle

10:30 **Penicillin – the de-labelling challenge**
Dr Louise Savic, Leeds

10:55 **Tea & coffee / poster viewing**

Chaired by Ms Joan Russell

11:25 **Capnography: no trace, wrong place**
Prof Jonathan Hardman, Nottingham

11:50 **Mathematical modelling of drug error: implications for safety interventions**
Prof Jaideep Pandit, Oxford

12:15 **What's dropped through your (electronic) mailbox?**
Dr Mike Nathanson, Nottingham

12:40 **Lunch / poster viewing**

Chaired by Prof Ravi Mahajan

13:40 **Checklists: are they all they're cracked up to be?**
Dr Tim Meek, Middlesbrough

14:05 **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)

14:30 **Equipment standards (and sausage dogs)**
Dr Harvey Livingstone, Liverpool

14:55 **Tea & coffee / poster viewing**

Chaired by Dr Craig Bailey

15:20 **Forcing error – driving innovation**
Dr Peter Young, King's Lynn

15:45 **Safety II: the safety of everyday clinical work**
Dr Alastair Ross, Glasgow

16:10 **Oral presentations and winner presentations**
Dr Craig Bailey, Chair of Safety Committee, Association of Anaesthetists

16:45 **Close of Meeting**

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.
3. Mathematics help preventative strategies.

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.
3. Blame culture.

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