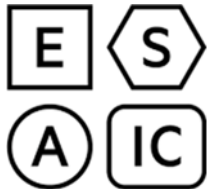


European Patient Safety and Quality Masterclass 2026

Day 1

- 09:00 Registration
- 09:30 Introduction round, participants' expectations
- 10:00 Safety Science I: The stories we tell...
- 11:00 Coffee Break
- 11:30 Human Factors I: Working with others in healthcare
- 12:15 Safety Science II: Do 'Bad Apples' exist?
- 13:00 Lunch break
- 14:00 Group 1 W 1 CRM
Group 2 W 2 System Analysis
- 15:30 Coffee Break
- 16:30 Group 2 W1 CRM
Group 1 W2 System Analysis
- 18:00 Day 1 wrap up



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Day 2

- 09:00 Welcome back Q&A
- 09:15 Safety Science III: Discovering the system
- 10:15 Human Factor II: Emergency Manuals - why bother?
- 10:45 Coffee break
- 11:15 Safety Science IV: Why things go right
- 12:00 Human Factor III: Impact of unexpected events
- 13:00 Lunch break
- 14:00 Quality workshop I
- 15:00 Coffee break
- 15:30 Quality workshop II
- 16:30 Coffee break
- 16:45 Pro-Con: Evidence based Patient Safety
- 17:30 Day 2 wrap up

Optional: Course Dinner



Day 3

- 08:30 Welcome back Q&A
- 08:45 Clinical case presentation
- 09:00 Crisis task force: analysis of the event & improvement planning (2/3 groups)
- 10:00 Coffee Break
- 10:15 Safety Science V: Just Culture (workshop)
- 11:00 Human Factors IV: Second Victims & mental health
- 12:00 Leadership in Patient Safety (workshop)
- 13:00 Q&A, resume, feedback
- 13:30 Lunch and goodbye



Content description

Safety Science I: Old vs. New view of Safety Hindsight bias, outcome bias, local rationality, systems view, dealing with error

Safety Science II: Coupling & Complexity. HRO Principles, Origins of Safety Science, TMI, Cognitive Psychology vs. Joint Cognitive Systems (Reason vs. Rasmussen)

Safety Science III: Normalization of deviance

Safety Science IV: Safety I, II, III; Resilience Engineering

Safety Science V: Just Culture approach, contemporary safety science perspective on algorithm use, experiences from other industries

Human Factors I: interactive lecture highlights how human capabilities to solve problems can also create dynamics and approaches that, in hindsight, would be considered „wrong“, and explores ways of dealing with them. focus on working with other professionals to achieve a common goal, even though the circumstances might not make it easy to do so.

Human Factors II: Basic features of human cognition in combination with time pressure, uncertainty, high stakes and stress during a critical situation set limits to human performance. Cognitive aids have come to be views as a promising tool in the management of perioperative events. However, their use is not widely disseminated. We will explore reasons for this translational gap and reflect upon possible solutions.

Human Factors III: Narrated experience

Human Factors IV: Care of the second victim, Recovery for healthcare providers, Critical Incident Stress Management

Workshop W1: Crew Resource Management is a set of more or less complex rules of thumb that should help in preventing of and recovering form errors. In this workshop, we will explore, how the relevant principles can support the care for patients. When and where are the underlying principles usable. Where is their scope of application and how can they be implemented in practice? The workshop will be highly interactive.

Workshop W2: System Analysis (IRS). Systems approach vs. individual blame. Application of the London protocol for systematic incident analysis

Quality Workshop: Quality Workshop: Perioperative Quality - Concepts and Principles; Dimensions of Quality (Donabedian); “Value” in Healthcare (Porter); Measuring Safety and Quality, Quality Indicators; Basics of Practical QM