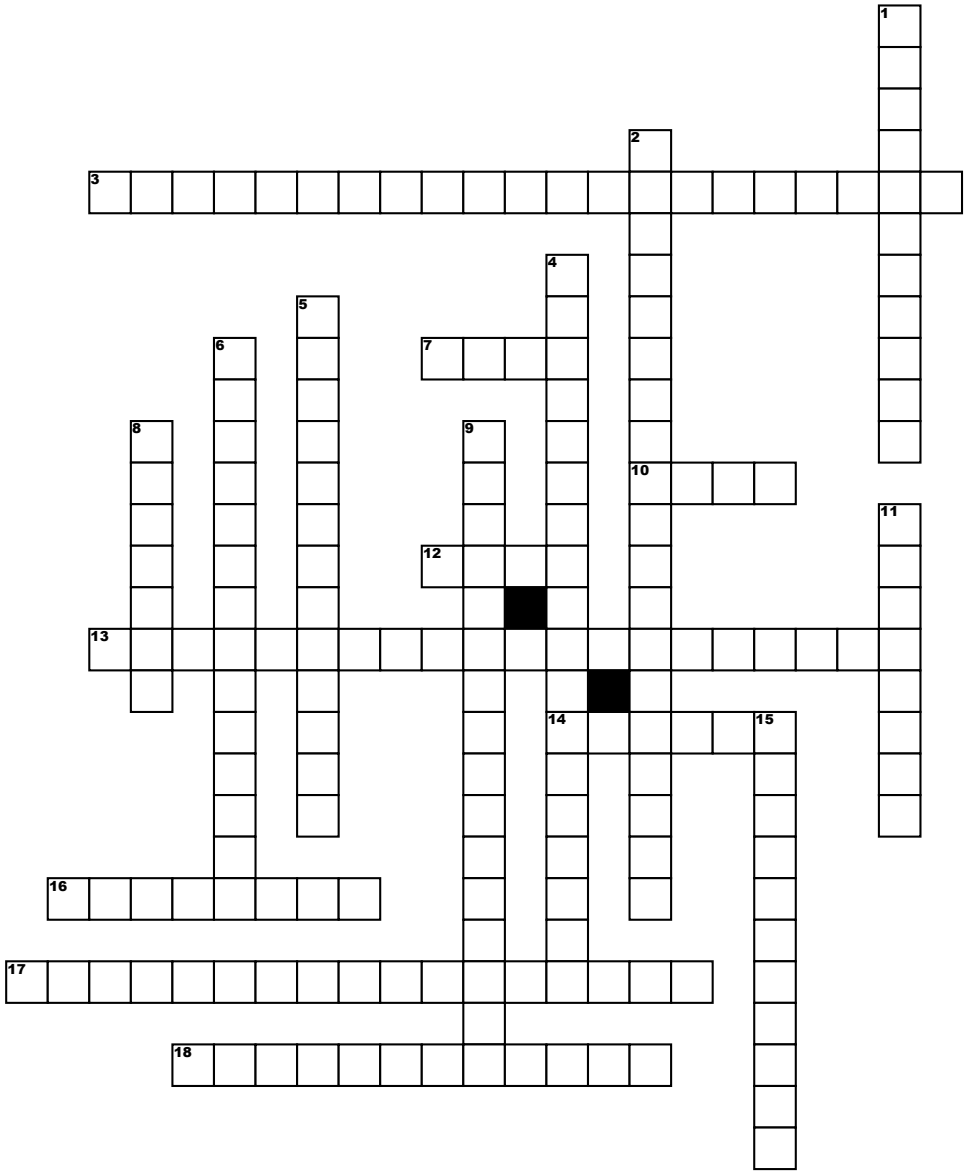
Name: _____ Date: _____

Safety



Across

3. Tool to help clarify questions

7. Self-Checking: Stop, Think, Act, Review

10. Communication tool for issues requiring action: Situation, Background, Assessment, Recommendation

12. System used to report incidents

13. An event reaching the patient causing minimal or no detectable harm

14. Structured hand-off: Patient/Project, Plan, Purpose, Problems, Precatutions

16. Any happening which is not consistent with the routine operation of a facility, service or care that is likely to lead to an adverse event

17. Non-punitive acknowledgement of incidents to promote quality management practice

18. Questioning attitude to validate and verify

Down

1. Ask questions, request a change, voice a concern, invoke chain of command

2. An event that does NOT reach the patient caught by detection barrier

4. An event that occurs reaching the patient causing moderate to severe harm

5. Safe guards placed to help prevent error

6. Near miss safety events often lead to

8. The shared values and beliefs of the individuals in the organization

9. We can avoid most error by practicing

11. set of instruction to guide the care of a patient

15. High risk situation + High risk behavior =