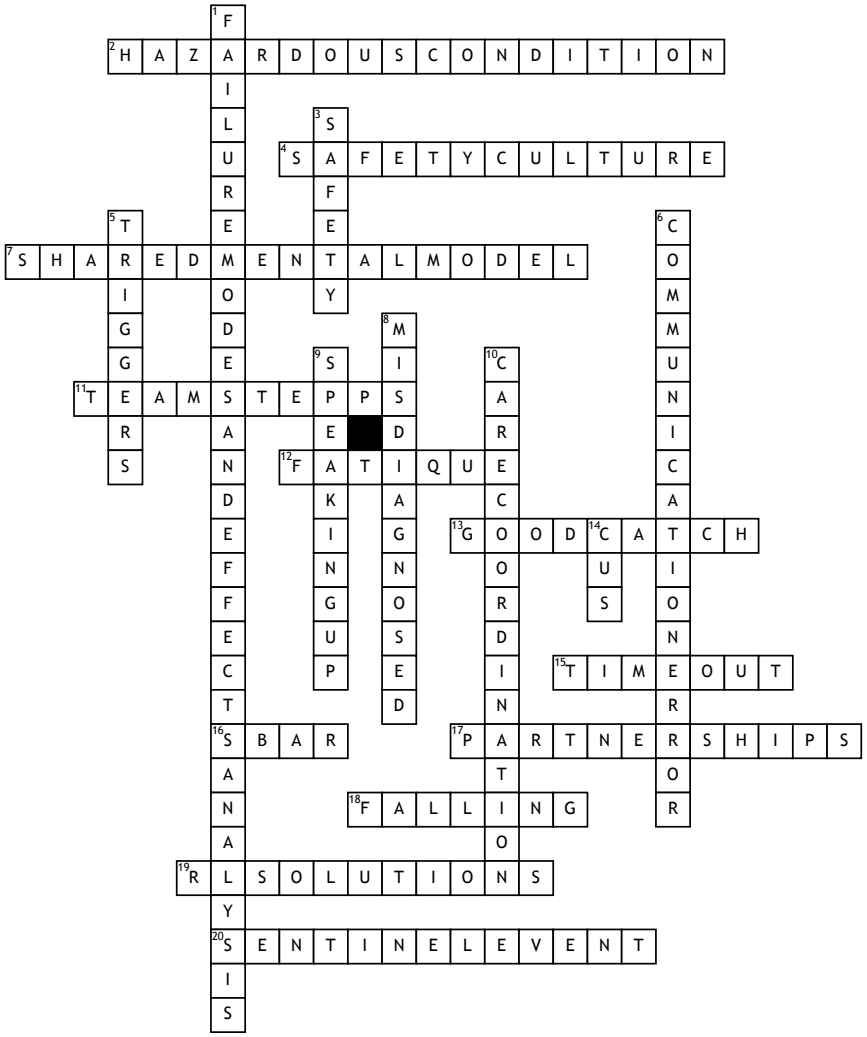
Name: _____ Date: _____

2019 Patient Safety Puzzle



Across

2. A circumstance that may increase the probability of an adverse event.

4. Group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organizations' commitment to quality and patient safety.

7. A _____ _____ _____ brings clarity and a common purpose to patient safety work.

11. _____ is an evidence-based framework for optimizing team performance across an organization.

12. Extended or double shifts may lead to _____, a human factor that could result in an error.

13. A _____ _____ is an error that was identified before it reached the patient.

15. Planned periods of quiet and/or interdisciplinary discussion focused on ensuring key procedural details have been addressed.

16. A technique used to facilitate prompt and appropriate communication.

17. Patient engagement results when staff create _____ with patients and involve them in self-care activities.

18. Age, condition, and medications may increase a patient's risk of _____.

19. A place for collecting, managing, and reporting safety events.

20. A patient safety event (not primarily related to the natural course of patient illness or underlying condition) that reaches the patient and results in either death, permanent harm, or severe temporary harm.

Down

1. A tool used to help organizations conduct proactive risk assessments.

3. _____ is the condition of being free from harm or risk, as a result of prevention and mitigation strategies.

5. _____ are signals that precede adverse events and when identified, they may help catch errors before they reach the patient.

6. _____ _____ is the #1 cause of medical errors.

8. A wrong label placed on a specimen may result in the patient being _____.

9. A program implemented by The Joint Commission to educate patients about healthcare processes and potential safety issues and to encourage them to speak up when they have safety concerns.

10. A strategy that has the potential to improve the effectiveness, safety, and efficiency of a healthcare system.

14. A method used to express concern about an unsafe situation, "I am Concerned, I am Uncomfortable!, This is a Safety issue!

Word Bank

TeamStepps
Misdiagnosed
CUS
Sentinel Event
Safety Culture
Fatique
Shared Mental Model
Time out
RL Solutions
Safety
Hazardous Condition
Communication Error
Care Coordination
Failure Modes and Effects Analysis
SBAR
Falling
Good Catch
Speaking Up
Triggers
Partnerships