|  |  |
| --- | --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

PATIENT SAFETY

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 1  A |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | S |  |  |  |  |
|  |  |  |  |  | 2  M | E | D | I | C | A | T | I | O | N | S |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | E |  |  |  |  |
|  |  |  |  | 3  R |  |  |  |  | 4  I |  |  |  |  |  | S |  |  |  |  |
|  | 5  S | A | F | E | T | Y |  |  | D |  |  |  |  |  | S |  |  |  |  |
|  |  |  |  | C |  |  |  |  | E |  | 6  H |  |  |  | M |  |  | 7  P |  |
|  |  |  |  | O |  |  | 8  H | A | N | D | O | F | F |  | E |  |  | H |  |
|  |  |  |  | N |  |  |  |  | T |  | U |  |  |  | N |  |  | Y |  |
|  |  |  |  | C |  |  |  |  | I |  | R |  | 9  O | U | T |  |  | S |  |
|  |  |  |  | I |  |  |  |  | F |  | L |  |  |  |  |  |  | I |  |
|  |  |  |  | L |  |  |  |  | I |  | Y |  |  |  |  |  |  | C |  |
|  |  |  |  | I |  | 10  S | E | V | E | N |  |  |  |  |  |  |  | I |  |
|  |  |  |  | A |  |  |  |  | R |  |  |  |  |  | 11  Y |  |  | A |  |
|  |  | 12  P | A | T | I | E | N | T | S | A | F | E | 13  T | Y | E | V | E | N | T |
|  |  |  |  | I |  |  |  |  |  |  |  |  | E |  | L |  |  |  |  |
|  |  |  |  | O |  |  |  |  |  |  |  |  | A |  | L |  |  |  |  |
|  |  |  |  | N |  |  |  |  |  |  | 14  T | I | M | E | O | U | T |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | W |  |  |  |  |

|  |  |
| --- | --- |
| **Across**  **2.** All patients should be asked for their list of current.  **5.** A culture of \_\_\_\_\_\_\_\_\_ encourages and supports the reporting of any situation that threatens the quality of patient care.  **8.** Communication between department and shift is enhanced when proper \_\_\_\_\_\_\_\_\_ are made.  **9.** Foam in Foam \_\_\_\_\_\_\_?  **10.** Number of Patient Safety goals?  **12.** A fall with injury, preventable stage II pressure ulcer, delay in treatment and wrong site procedure are all examples of what?  **14.** Necessary prior to procedure. | **Down**  **1.** What is the A in SBAR?  **3.** Going over a patients medications upon discharge is medication.  **4.** Name and birthdate are patient \_\_\_\_\_\_\_\_\_?  **6.** What type of rounding prevents falls?  **7.** Critical test results must be called to the.  **11.** The color used to represent patients as a high risk for a fall?  **13.** We act as a \_\_\_\_\_\_\_\_\_ to keep patients safe? |