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

The Misfits

|  |  |
| --- | --- |
| **1.** Two examples of these: "Prevent mistakes in surgery" and "Improve staff communication" | **A.** Unit Leadership |
| **2.** If patients or families have concerns during their stay they can call the \_\_\_\_\_\_\_\_ line. | **B.** Reporting |
| **3.** If team members have concerns about patients they can utilize the \_\_\_\_\_\_\_\_. | **C.** Language Services |
| **4.** If you as team member receive a request involving protected characteristics who do you engage? | **D.** Comment |
| **5.** For PATIENT FOCUSED EVENTS, near misses, good catches, etc. we complete an \_\_\_\_\_\_\_\_. | **E.** HEART |
| **6.** For TEAM MEMBER FOCUSED EVENTS ie. injuries, exposures, safety concerns we use the \_\_\_\_\_\_\_\_\_\_ event reporting system. | **F.** Resource Guide |
| **7.** \_\_\_\_\_\_\_\_ your safety stories is so important because it alerts operational leadership and risk management of potential and actual safety issues and prevents reoccurrence. | **G.** Root Cause Analysis |
| **8.** If a sentinel event defined as a "patient safety event that reaches a patient results in severe temporary harm, permanent harm or death and/or events defined by regulatory agencies" occurs a \_\_\_\_\_\_\_\_ is required. | **H.** ERS |
| **9.** The model that stands for Hear, Empathize, Apologize, Resolve or Refer, and Thank Them is what?  | **I.** Condition Concern |
| **10.** These cards should be available and visible in each unit to allow patients to provide feedback. | **J.** National Patient Safety Goals |
| **11.** The blue bifold folders inform patients of their rights and should be located in every patient room.  | **K.** Help Chain |
| **12.** This team is available to accommodate our Limited English Proficient patients and the Deaf and Hard of Hearing population and can be found via Voalte under "Interpreter". | **L.** Safety Pause |