ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

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2019 Patient Safety Word Search

B W O F K X W N E M F M S W H T J D B T
R E R H V L E S R O H I P Y Z V T F C U
K T N A M A J D R Y A T F L T M K F M A
V S H C R J F A O H T I Z Y C T D O P B
H I I M H O U Q R W Q G C L M W C D K Y
U Q I R E M C H U W B A S V F C O N J L
Y S Q V S D A Y P G H T F W K M R A H E
S Z E P I M E R W G U I F G Y D A H R L
W N N F V X C P K P B O L O D Q P Q F J
T K H G P Z A F Q I M N Y G I K P I A Q
Y F T I O S N L F A N A A R N L K P P O
T X Y C Y P J N T S Y G M I C V M D R V
M T N E D I C N I T A H R U C M J H P R
X U O M Q F P O I G F F E E E E I N F P
S R A Q L A R L W N T Q E R R G J O X Q
F K Q A M Q A E D H X G H T D U Z P S K
P U M K W U C A N D O R C F Y M T B W M
G A Z E Q O S R C Y E N D F H R J L N O
M L E E B K L L O N R D E P W Q X J U C
Q B F L X P E H L A A O O F V I Z Z P C

NEAR MISS
HARM
CULTURE
ERROR
CANDOR
ERM
BENCHMARKING
MITIGATION
RISK
SAFETY
INCIDENT
HANDOFF
EVENT
QUALITY
HRO

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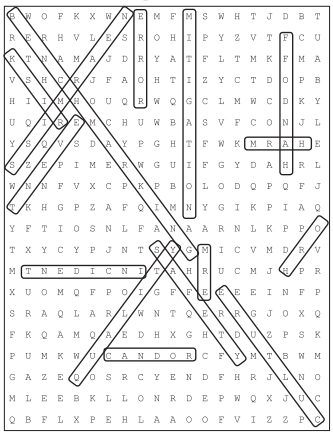
Answer Key



Patient Safety Word Search Definitions

Near miss: a patient is exposed to a hazardous situation but does not experience harm (either through luck or early detection). Source: AHRQ

Harm: extent to which the patient's functional ability is expected to be impaired subsequent to the incident and any attempts to minimize adverse consequences. Source: ASHRM Whitepaper Serious Safety Events: A Focus on Harm Classification

Culture: the integrated pattern of human knowledge, values, belief, and behavior that depends upon the capacity for learning and transmitting knowledge. Source: NQF

Error: the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim (commission). Source: Committee on Data Standards for Patient Safety, Institute of Medicine

CANDOR: is a process that health care institutions and practitioners can use to respond in a timely, thorough, and just way when unexpected events cause patient harm. Source: AHRQ – Patient Safety Tools

ERM: enterprise risk management (ERM) in health care promotes a comprehensive framework for making risk management decisions which maximize value protection and creation by managing risk and uncertainty and their connections to total value. Source: ASHRM

Benchmarking: a methodology used for the health care organization and professionals to compare and analyze their quality/risk data to other like data sets. Source: ASHRM – Patient Safety Playbook

Mitigation: an action or circumstance which prevents or moderates the progression of an incident towards harming a patient. Source: WHO – International Classification for Patient Safety

Risk: possibility of loss or injury. Source: Merriam Webster

Safety: the condition of being free from harm or risk, as a result of prevention mitigation strategies. Source: Merriam Webster

Incident: a patient safety event that reached the patient, whether or not the patient was harmed. Source: ARHQ – Common Formats

Handoff: the process of transferring responsibility of care. Source: AHRQ – Patient Safety Primer

Event: a discrete, auditable and clearly defined occurrence. Source: NQF – Standardizing a Patient Safety Taxonomy

Quality: the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Source: Committee on Quality of Health Care in America, Institute of Medicine

HRO: high reliability organization (HRO) are organizations that operate in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures. Source: AHRQ – Patient Safety Primers