In our experience Green Cross is a simple method of achieving greater patient safety and an improved patient safety culture.

Interested in finding out how your organization can improve its patient safety and patient safety culture? Read more here.

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Green Cross – the safety cross implemented in a hospital setting

Green Cross is a simple visual method for health service staff to recognize risks and avoidable patient injuries in real time on a daily basis, thus creating a foundation for targeted, systematic daily work on improvements that increases patient safety and strengthens patient safety culture.

Patient safety implies an absence of avoidable patient injury.

Patient injury is defined as pain, physical or mental injury or illness, and death that could have been avoided if adequate measures had been taken when the patient came into contact with the health service (SFS 2010:659).

A good safety culture is considered crucial in maintaining good safe care.

Background to the Green Cross

After several serious adverse events that had not been noticed, the idea arose of creating a visual method that would make staff more aware of risks and negative events.

On an industrial study visit in 2011 Lars Rex, Head of the Surgical Clinic, saw a method of visually reproducing workplace risks and accidents, Safety Cross. Development manager Katherina Hansson created a simple visual analogue method adapted for health and medical care. The method facilitates daily identification of risks and avoidable patient injuries where staff can themselves take some of the responsibility for reducing negative events and patient injuries.

The first pilot projects were run at the Surgical Clinic at Södra Älvsborg Hospital in the autumn of 2011 with the aid of the doctors’ group and on one ward. After good experiences and a positive response from staff and managers the method was extended to all surgical wards. Since 2012 development work has continued to be led by Katherina Hansson and Chief Medical Officer Jerker Isacson.

1. Identification

Every unit/ward meets daily for a cross-disciplinary audit meeting.

All units at the hospital discuss the previous day’s events and identify risks and avoidable patient injuries while the outpatient’s department takes up today’s events.

Has any employee discovered a patient injury or a risk of one?

2. Assessment of seriousness

General discussion of events, risks and patient injuries takes place and the degree of seriousness is assessed.

The degree of seriousness is illustrated on the basic template with the relevant colour code for the date concerned.

3. Data collection

A patient injury or risk of one is entered on the appropriate detailed report form which also becomes the monthly summary.

4. Non-conformance reporting

Accident/incident report is written the same day before the working day ends.

5. Patient/relative involved

Suggested improvements are asked for at every red or orange colour coding.

6. Improvements work

The engine of the whole machine ...

Systematic daily work on improvements by direct action to deal with risks as soon as they are identified or in planned teamwork.

Based on the monthly summaries long-term measures are taken to prevent the event being repeated. Green Cross raises awareness of what each unit needs to focus on in its work to improve patient safety.

7. Follow-up and learning

Unit level: Follow-up at unit level takes place at workplace meetings, at cross-disciplinary improvement meetings and in daily improvement work.

Clinic level: Follow-up is shown on the clinic’s planning boards where the net result is reported as a result and long-term measures are planned.

Hospital level: Follow-up is shown on general planning boards for patient safety culture and patient safety reporting.

Regional and national level: Follow-up is by means of action plans for patient safety culture and patient safety reporting.