

Appendix A – Setting-Level Demographics Survey

Diagnostic Safety Capacity Building – TeamSTEPPS® Resource
 Please complete the following information about your health care setting:

Form Approved OMB No. xxxx-xxxx Exp. Date xx/xx/20
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General Information About Your Health Care Setting

Health Care Setting Name		
Mailing Address (City, State, Zip code)		
Setting Facilitator or Champion (Name, Email, Telephone, Role, Title)		
Total number of beds in health system		
Total number of beds in health care setting (i.e., unit or practice) administering the Team Assessment Tool survey		
Total number of staff in the health system	Physicians _____ Physician Assistants _____ Nurse Practitioners _____ Nurses _____ Medical Assistants _____ Pharmacists _____ Other Health Care Setting Staff _____ Other (specify) _____	
Total number of staff in the health care setting administering the Team Assessment Tool survey		
Approximate Number of Patients Served by Health Care Setting	Weekly _____ Yearly _____	

Information about Patient Safety and Quality Improvement Activities of the Setting

	Yes	No
Does your setting routinely conduct a patient safety culture survey?	<input type="checkbox"/> Please specify which survey you use: _____ Date of the last survey: _____	<input type="checkbox"/>
Is your setting part of a larger healthcare system?	<input type="checkbox"/> Please indicate which health system you are affiliated with: _____	<input type="checkbox"/>
Is your setting currently working on any other setting improvement strategies?	<input type="checkbox"/>	<input type="checkbox"/>
Does your setting have or use the services of a setting facilitator, educator or quality improvement champion?	<input type="checkbox"/>	<input type="checkbox"/>
Is your setting familiar with TeamSTEPPS® tools or resources?	<input type="checkbox"/>	<input type="checkbox"/>
Does your setting use TeamSTEPPS® tools or resources?	<input type="checkbox"/>	<input type="checkbox"/>

This survey is authorized under 42 U.S.C. 299a. The confidentiality of your responses to this survey is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure. Public reporting burden for this collection of information is estimated to average 60 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-XXXX) AHRQ, 5600 Fishers Lane, Room #07W42, Rockville, MD 20857.