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

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?	❑ Please specify which survey you use: _____ Date of the last survey: _____	❑
Is your setting part of a larger healthcare system?	❑ Please indicate which health system you are affiliated with: _____	❑
Is your setting currently working on any other setting improvement strategies?	❑	❑
Does your setting have or use the services of a setting facilitator, educator or quality improvement champion?	❑	❑
Is your setting familiar with TeamSTEPPS® tools or resources?	❑	❑
Does your setting use TeamSTEPPS® tools or resources?	❑	❑