5-digit RAND ID:

OMNIBUS SURVEY OF DIAGNOSTIC SAFETY CULTURE: HOSPITALS

[Insert site name] and the RAND Corporation are collaborating to improve diagnostic excellence during inpatient care. *You are being asked to answer this survey because of your important role in improving the safety and quality of inpatient care.*

This survey asks about aspects of your hospital's and your unit's culture. It should take no longer than 20 minutes to complete.

We are interested in learning about what it is like to work in your hospital and your unit. This survey asks for your opinions about patient safety issues, medical error, diagnostic error and event reporting in your hospital.

- **Patient safety** is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of healthcare delivery
- A **patient safety event** is defined as any type of healthcare-related error, mistake, or incident regardless of whether or not it results in patient harm
- A **diagnostic safety event** is defined as an event where one or both of the following occurred, whether or not the patient was harmed:
    o Delayed, wrong or missed diagnosis: There were one or more missed opportunities to pursue or identify an accurate and timely diagnosis (or other explanation) of the patient's health problem(s) based on the information that existed at the time.
    o Diagnosis not communicated to patient: An accurate diagnosis (or other explanation) of the patient's health problem(s) was available, but it was not communicated to the patient (includes patient's representative or family as applicable).

RAND will combine your survey answers with the answers from others who complete the survey to produce only summary results. When presenting survey results, RAND will not include your name or any other information that could identify you.

If you have questions about this research or how to answer any of the questions, please contact Dr. Denise D. Quigley, at RAND at quigley@rand.org.

2
5-digit RAND ID:

YOUR HOSPITAL AND YOUR CURRENT POSITION

FILL IN YOUR HOSPITAL NAME:_____

1. **What is your position in the hospital? (Please select one answer):**
   Nursing
   ☐ Advanced Practice Nurse (NP, CRNA, CNS, CNM)
   ☐ Licensed Vocational Nurse (LVN), Licensed Practical Nurse (LPN)
   ☐ Patient Care Aide
   ☐ Registered Nurse (RN)

   Medical
   ☐ Physician Assistant
   ☐ Resident, Intern
   ☐ Physician, Attending, Hospitalist

   Other Clinical Position
   ☐ Dietitian
   ☐ Pharmacist, Pharmacy Technician
   ☐ Physical, Occupational, or Speech Therapist
   ☐ Psychologist
   ☐ Respiratory Therapist
   ☐ Social Worker
   ☐ Technologist, Technician (e.g. EKG, lab, Radiology)

   Supervisor, Manager, Clinical Leader, Senior Leader
   ☐ Supervisor, Manager, Department Manager, Clinical leader, Administrator, Director
   ☐ Senior Leader, Executive, C-Suite

   Other Role
   ☐ Other Role

5-digit RAND ID:

2. **Some hospitals have <u>an improvement team that includes a focus on diagnostic safety events</u>.** This means that your hospital has identified and recruited individuals at your hospital that are knowledgeable about any effort or intervention to reduce or prevent **diagnostic errors** (e.g., risk managers, quality directors, clinicians from the ED, radiology, lab, ICUs, nurses, pharmacists, members of your hospital's patient and family advisory council (PFAC), board members, and others).

   Does your hospital have an improvement team that includes a focus on <u>diagnostic safety events</u>?
   ☐ No
   ☐ Yes

3. **Are you part of the improvement team that includes a focus on <u>diagnostic safety events</u>?**
   ☐ No
   ☐ Yes, as a member
   ☐ Yes, as a team leader

4. **How many years have you worked in this hospital in your current role?**
   [dropdown of years <6 months, 7-12 months, 1, 2, etc. through 70+]

5. **How many years have you worked in this hospital?**
   [dropdown of years <6 months, 7-12 months, 1, 2, etc. through 70+]

   YOUR PERSPECTIVE ON PRIORITIES WITHIN YOUR HOSPITAL

We are interested in your perspective about the priorities at **your Hospital**. Please consider all units across your hospital in your answers.

(6) Within ***your Hospital***, how important is patient safety compared to other goals?

Other Goals	Patient safety is <u>less important</u>	Patient safety is of the <u>same importance</u>	Patient safety is <u>more important</u>
a. Patient experience	⭕	⭕	⭕
b. Clinical quality of care	⭕	⭕	⭕
c. Financial performance of the hospital	⭕	⭕	⭕

5-digit RAND ID:

IMPROVING PATIENT SAFETY

(7) In the last 6 months, did *your Hospital* work to implement any of the following practices as it relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient)?

	Not Implemented		Partially implemented		Fully Implemented
a. Health care organization leadership builds a "board-to-bedside" accountability framework that includes structure, capacity, transparency, time, and resources to measure and improve diagnostic safety.	O	O	O	O	O
b. Health care organization promotes a just culture and creates a psychologically safe environment that encourages clinicians and staff to share opportunities to improve diagnostic safety without fear of retribution	O	O	O	O	O
c. Health care organization creates feedback loops to increase information flow about patients' diagnostic and treatment-related outcomes. These loops, which include clinicians and external organizations, establish mechanisms for capturing, measuring, and providing feedback to the diagnostic team about patients' subsequent diagnoses and clinical outcomes.	O	O	O	O	O
d. Health care organization includes multidisciplinary perspectives to understand and address contributory factors in analysis of diagnostic safety events. These perspectives include human factors, informatics, IT system design, and cognitive elements.	O	O	O	O	O
e. Health care organization actively seeks patient and family feedback to identify and understand diagnostic safety concerns and addresses concerns by codesigning solutions.	O	O	O	O	O

5-digit RAND ID:

Question 7 Continued

In the last 6 months, did **your Hospital** work to implement any of the following practices as it relates to reducing errors in diagnosis (including delayed, wrong, or missed diagnoses, and diagnoses not communicated to the patient)?

	Not Implemented		Partially implemented		Fully Implemented
f. Health care organization encourages patients to review their health records and has mechanisms in place to help patients understand, interpret, and/or act on diagnostic information.	O	O	O	O	O
g. Health care organization prioritizes equity in diagnostic safety efforts by segmenting data to understand root causes and implementing strategies to address and narrow equity gaps.	O	O	O	O	O
h. Health care organization has in place standardized systems and processes to encourage direct, collaborative interactions between treating clinical teams and diagnostic specialties (e.g., laboratory, pathology, radiology) in cases that pose diagnostic challenges.	O	O	O	O	O
i. Health care organization has in place standardized systems and processes to ensure reliable communication of diagnostic information between care providers and with patients and families during handoffs and transitions throughout the diagnostic journey	O	O	O	O	O
j. Health care organization has in place standardized systems and processes to close the loop on communication and follow up on abnormal test results and referrals.	O	O	O	O	O
k. Training clinicians and others involved in the diagnostic process to use evidence-based tools and strategies to collect complete and accurate personal health information from patients and family to facilitate timely and accurate diagnosis.	O	O	O	O	O
l. Ensuring that the hospital EHR captures the correct diagnosis by having a process in place to review, update and correct inaccurate diagnoses on "problem lists" and elsewhere in the EHR.	O		O		O
m. Providing patients and families whose preferred language for medical information differs from their care team with professional medical interpreters (on-site, video, phone) to assist with obtaining health information.	O	O	O	O	O
n. Providing clinicians with access to radiologists 24 hours a day, 7 days a week (onsite or remote) to read and interpret urgent an emergent imaging studies and provide timely input on imaging test selection.	O	O	O	O	O

5-digit RAND ID:

	Not Implemented		Partially implemented		Fully Implemented
o. Having a quarterly process by which radiologists and pathologists identify cases where a pathology finding is discrepant with clinical or imaging impressions and then jointly review and reconcile any discrepant findings.	O	O	O	O	O
p. Conducting risk assessment of commonly misdiagnosed high-risk conditions in the ED to ensure it has access to clinical expertise and technologies needed to achieve timely and accurate diagnosis.	O	O	O	O	O
q. Integrating knowledge resources into the clinical workflow to help clinicians improve their diagnosis in real-time for cases where there is diagnostic uncertainty and educates and incentivizes (e.g., through a performance evaluation) clinicians to use these resources.	O	O	O	O	O
r. Training clinicians to optimize clinical reasoning in the diagnostic process	O	O	O	O	O
s. Having evidence-based clinical pathways for diagnosis in the ED and measures the consistency of their implementation and their impact on diagnostic performance (e.g., post-ED hospitalizations or mortality).	O	O	O	O	O
t. Implementing policy that outlines the protocol(s) care team members should take when handing off patients with diagnostic uncertainty to the care team assuming responsibility for the next phase of care, including different units within the same hospital (e.g., ED to inpatient unit, hospital to skilled nursing facility, general hospital to free-standing pediatric hospital, hospital to primary care physician, to and from intensive care units, between specialty services, etc.).	O	O	O	O	O
u. Ensuring patients discharged with an uncertain diagnosis or where potential diagnoses involve high-risk conditions have a discharge summary and explicit condition-specific instructions.					
v. Improving process and protocol in place to ensure that patients are discharged from the ED or hospital with both a list of lab and imaging test results and list of any pending test results and written instructions, in the patient's preferred language for medical decision-making, on how to obtain those results.	O	O	O	O	O
w. Implementing a policy that outlines the responsibilities of each care team member to ensure all critical and subcritical test results, including those pending at discharge, are viewed by the appropriate care team and communicated to the patient in an appropriate timeframe based on the result.	O	O	O	O	O

7
5-digit RAND ID:

YOUR PERSPECTIVE ON MEASUREMENT STRATEGIES

(8) Based on your experiences in the last 6 months, how much do you disagree or agree with the following statements about *your Hospital's* **measurement strategies on diagnostic safety events**?

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
a. I am familiar with the measurement of diagnostic safety events for learning and improvement.	O	O	O	O	O
b. Our diagnostic safety event data and results provide information sufficient for learnings.	O	O	O	O	O
c. Our diagnostic safety data and results provide information specific enough for use in improvement.	O	O	O	O	O
d. Diagnostic safety measurement activities are conducted in a way that safeguard the privacy and confidentiality of involved <u>clinicians</u>	O	O	O	O	O
e. Diagnostic safety measurement activities are conducted in a way that safeguard the privacy and confidentiality of involved <u>patients</u>	O	O	O	O	O
f. This Hospital has enough resources to use diagnostic safety data for learning and improvement.	O	O	O	O	O
g. This Hospital promotes awareness of diagnostic safety in the context of routine educational and operational functions	O	O	O	O	O
h. This Hospital's leadership supports measurement of diagnostic safety events (e.g., event data, clinician reports, EHR chart review, patient information, etc.)	O	O	O	O	O
i. Diagnostic Safety Team members have support from others at this Hospital who are also willing to learn in pursuit of diagnostic excellence	O	O	O	O	O

5-digit RAND ID:

YOUR UNIT/WORK AREA

Think of your "unit" as the work area, department, or clinical area of the hospital where you spend *most* of your work time.

(10) What is your primary unit or work area in this hospital? Please select one answer.

Multiple Units, No specific unit
¨1 Many different hospital units, No specific unit

Medical/Surgical Units
¨2 Combined Medical/Surgical Unit
¨3 Medical Unit (Non-Surgical)
¨4 Surgical Unit

Patient Care Units
¨5 Cardiology
¨6 Emergency Department, Observation, Short Stay
¨7 Gastroenterology
¨8 ICU (all adult types)
¨9 Labor & Delivery, Obstetrics & Gynecology
¨10 Oncology, Hematology
¨11 Pediatrics (including NICU, PICU)
¨12 Psychiatry, Behavioral Health
¨13 Pulmonology
¨14 Rehabilitation, Physical Medicine
¨15 Telemetry

Surgical Services
¨16 Anesthesiology
¨17 Endoscopy, Colonoscopy
¨18 Pre Op, Operating Room/Suite, PACU/Post Op, Peri Op

Clinical Services
¨19 Pathology, Lab
¨20 Pharmacy
¨21 Radiology, Imaging
¨22 Respiratory Therapy
¨23 Social Services, Case Management, Discharge Planning

Administration/Management
¨24 Administration, Management
¨25 Financial Services, Billing
¨26 Human Resources, Training
¨27 Information Technology, Health Information Management, Clinical Informatics
¨28 Quality, Risk Management, Patient Safety

Other
¨34 Other, please specify:

5-digit RAND ID:

YOUR PERSPECTIVE ON THE WORK ENVIRONMENT IN YOUR UNIT/WORK AREA

We would like to know about the work environment in the unit where you spend most of your work time

(11) Based on your experiences in the last 6 months, how much do you disagree or agree with the following statements about **your unit/work area**?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
a. In this unit, we work together as an effective team	O	O	O	O	O	O
b. In this unit, we have enough staff to handle the workload.	O	O	O	O	O	O
c. This unit regularly reviews work processes to determine if changes are needed to improve patient safety.	O	O	O	O	O	O
d. In this unit, staff feel like their mistakes are held against them.	O	O	O	O	O	O
e. When an event is reported in this unit, it feels like the person is being written up, not the problem.	O	O	O	O	O	O
f. When staff make errors, this unit focuses on learning rather than blaming individuals.	O	O	O	O	O	O
g. In this unit, changes to improve patient safety are evaluated to see how well they worked.	O	O	O	O	O	O
h. In this unit, there is a lack of support for staff involved in patient safety errors.	O	O	O	O	O	O
i. This unit lets the same patient safety problems keep happening.	O	O	O	O	O	O

5-digit RAND ID:

YOUR PERSPECTIVE ON COMMUNICATION IN YOUR UNIT/WORK AREA

We would like to know about communication in the unit where you primarily work.

(12) How often do the following things happen in your unit/work area?

	Never	Rarely	Sometimes	Most of the time	Always	Does Not Apply or Don't Know
a. We are informed about errors that happen in this unit.	O	O	O	O	O	O
b. When errors happen in this unit, we discuss ways to prevent them from happening again.	O	O	O	O	O	O
c. In this unit, we are informed about changes that are made based on event reports.	O	O	O	O	O	O
d. In this unit, staff speak up if they see something that may negatively affect patient care.	O	O	O	O	O	O
e. When staff in this unit see someone with more authority doing something unsafe for patients, they speak up.	O	O	O	O	O	O
f. When staff in this unit speak up, those with more authority are open to their patient safety concerns.	O	O	O	O	O	O
g. In this unit, staff are afraid to ask questions when something does not seem right.	O	O	O	O	O	O
h. When a mistake is caught and corrected before reaching the patient, how often is this reported?	O	O	O	O	O	O
i. When a mistake reaches the patient and could have harmed the patient, but did not, how often is this reported?	O	O	O	O	O	O

5-digit RAND ID:

YOUR PERSPECTIVE ON PROCESSES AROUND DIAGNOSIS IN YOUR UNIT/WORK AREA

The following items ask about your unit/work area's processes around diagnosis. The processes start when a patient seeks care for a health problem and include:
- Gathering, integrating, and interpreting information about the patient (e.g., clinical history, physical exam, test and imaging results, referrals).
- Making an initial diagnosis.
- Discussing the diagnosis with the patient, and
- Following the patient and revising the diagnosis, as needed.

In this part of the survey, the term "provider" refers to physicians, physician assistants, and nurse practitioners who diagnose, treat patients, and prescribe medications. The term staff refers to all others who work in the unit.

(9) How much do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
Time Availability						
a. The amount of time that providers have with each patient is long enough to fully evaluate the patient's presenting problem(s).	O	O	O	O	O	O
b. Providers in this unit have enough time to review the relevant information related to the patient's presenting problem(s).	O	O	O	O	O	O
c. Providers in this unit finish their patient notes by the end of their regular workday.	O	O	O	O	O	O
Testing and Referrals						
d. This unit is effective at tracking a patient's test results from labs, imaging, and other diagnostic procedures.	O	O	O	O	O	O
e. When this unit doesn't receive a patient's test results, staff follow up.	O	O	O	O	O	O
f. All test results are communicated to patients, even if the test results are normal.	O	O	O	O	O	O
g. When this hospital makes a high priority referral, we try to have the appointment scheduled before the patient is discharged.	O	O	O	O	O	O
Provider and Staff Communication Around Diagnosis						
h. Providers in this unit encourage other staff to share their concerns about a patient's health	O	O	O	O	O	O

5-digit RAND ID:

condition.						
i. Providers document differential diagnoses when they have **not** ruled out other diagnoses.	O	O	O	O	O	O
j. When a provider thinks another provider in this unit/hospital/system may have missed a diagnosis, they inform that provider.	O	O	O	O	O	O
k. When a missed, wrong, or delayed diagnosis happens in this unit, we are informed about it.	O	O	O	O	O	O
l. Providers in this unit talk directly with specialists/radiologists/pathologists when something needs clarification.	O	O	O	O	O	O

(13) Is there anything else you'd like to share with us regarding *your hospital's* diagnostic safety measurement, review of diagnostic safety events and/or improvement efforts?

_____

_____

_____

_____

We appreciate your involvement in this important effort.

Thank you!

5-digit RAND ID: