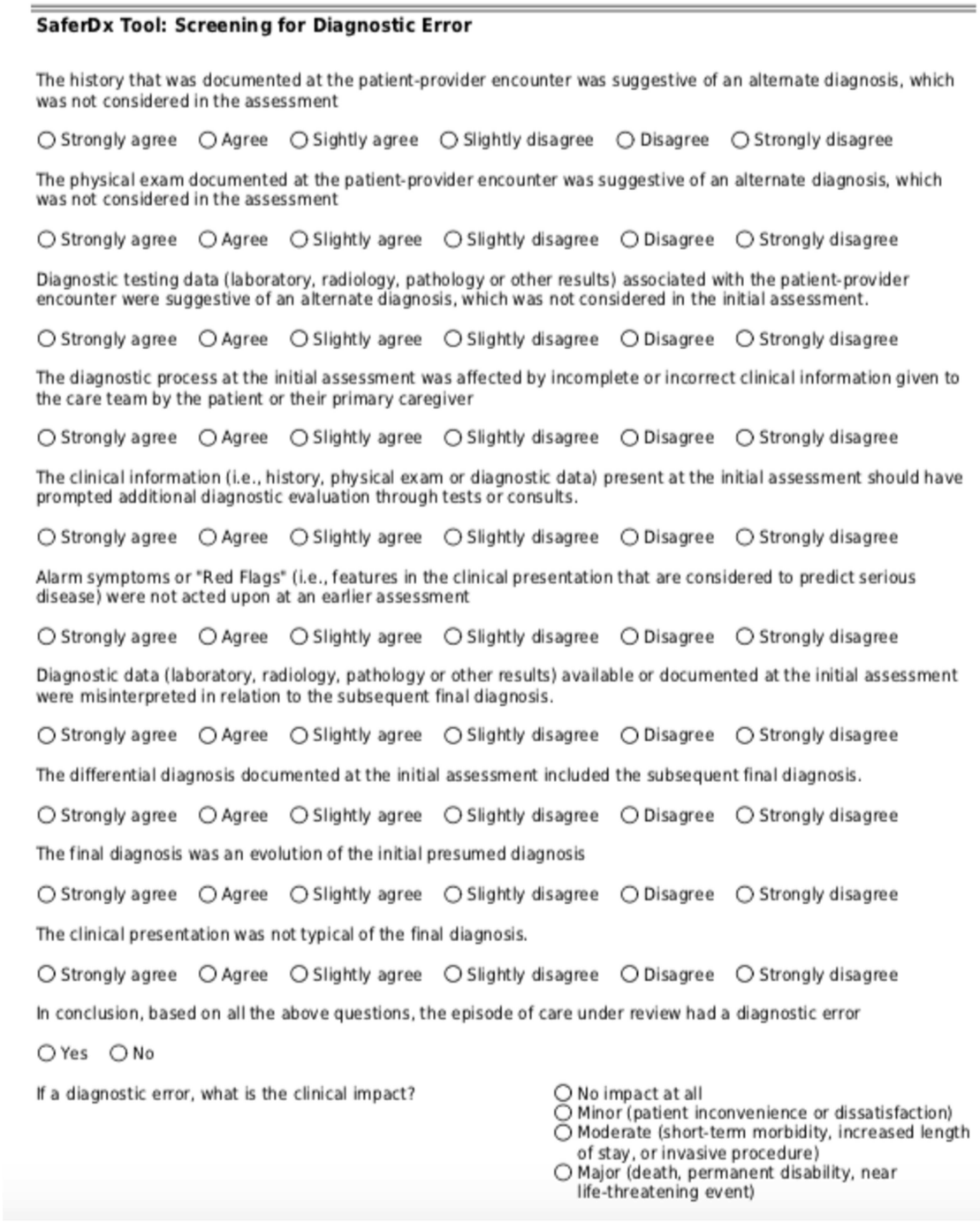
Figure 1: Safer Dx Tool



SaferDx Tool: Screening for Diagnostic Error

The history that was documented at the patient-provider encounter was suggestive of an alternate diagnosis, which was not considered in the assessment

○ Strongly agree ○ Agree ○ Sightly agree ○ Slightly disagree ○ Disagree ○ Strongly disagree

The physical exam documented at the patient-provider encounter was suggestive of an alternate diagnosis, which was not considered in the assessment

○ Strongly agree ○ Agree ○ Slightly agree ○ Slightly disagree ○ Disagree ○ Strongly disagree

Diagnostic testing data (laboratory, radiology, pathology or other results) associated with the patient-provider encounter were suggestive of an alternate diagnosis, which was not considered in the initial assessment.

○ Strongly agree ○ Agree ○ Slightly agree ○ Slightly disagree ○ Disagree ○ Strongly disagree

The diagnostic process at the initial assessment was affected by incomplete or incorrect clinical information given to the care team by the patient or their primary caregiver

○ Strongly agree ○ Agree ○ Slightly agree ○ Slightly disagree ○ Disagree ○ Strongly disagree

The clinical information (i.e., history, physical exam or diagnostic data) present at the initial assessment should have prompted additional diagnostic evaluation through tests or consults.

○ Strongly agree ○ Agree ○ Slightly agree ○ Slightly disagree ○ Disagree ○ Strongly disagree

Alarm symptoms or "Red Flags" (i.e., features in the clinical presentation that are considered to predict serious disease) were not acted upon at an earlier assessment

○ Strongly agree ○ Agree ○ Slightly agree ○ Slightly disagree ○ Disagree ○ Strongly disagree

Diagnostic data (laboratory, radiology, pathology or other results) available or documented at the initial assessment were misinterpreted in relation to the subsequent final diagnosis.

○ Strongly agree ○ Agree ○ Slightly agree ○ Slightly disagree ○ Disagree ○ Strongly disagree

The differential diagnosis documented at the initial assessment included the subsequent final diagnosis.

○ Strongly agree ○ Agree ○ Slightly agree ○ Slightly disagree ○ Disagree ○ Strongly disagree

The final diagnosis was an evolution of the initial presumed diagnosis

○ Strongly agree ○ Agree ○ Slightly agree ○ Slightly disagree ○ Disagree ○ Strongly disagree

The clinical presentation was not typical of the final diagnosis.

○ Strongly agree ○ Agree ○ Slightly agree ○ Slightly disagree ○ Disagree ○ Strongly disagree

In conclusion, based on all the above questions, the episode of care under review had a diagnostic error

○ Yes ○ No

If a diagnostic error, what is the clinical impact?

○ No impact at all
○ Minor (patient inconvenience or dissatisfaction)
○ Moderate (short-term morbidity, increased length of stay, or invasive procedure)
○ Major (death, permanent disability, near life-threatening event)

Figure 2: Diagnostic Error Evaluation and Research (DEER) Taxonomy survey

DEER Taxonomy for Categorizing Diagnostic Error	
1. Access/Presentation	☐ Failure/delay in presentation ☐ Failure/denied care access
2. History	☐ Failure/delay in eliciting a critical piece of history data ☐ Inaccurate/misinterpreted critical piece of history data ☐ Suboptimal weighing of a critical piece of history data ☐ Failure/delay to follow-up on a critical piece of history data
3. Physical Examination	☐ Failure/delay in eliciting a critical physical exam finding ☐ Inaccurate/misinterpreted critical physical exam finding ☐ Suboptimal weighing of a critical physical exam finding ☐ Failure/delay in following up on a critical physical exam finding
4. Tests (Laboratory/Radiology)	☐ Failure/delay in ordering needed test(s) ☐ Failure/delay in performing ordered test(s) ☐ Suboptimal test sequencing ☐ Ordering of wrong test(s) ☐ Test ordered wrong way ☐ Sample mix-up/mislabel ☐ Technical errors/poor processing of specimen/test ☐ Erroneous laboratory/radiology reading of test ☐ Failed/delayed transmission of result to clinician ☐ Failed/delayed follow-up action on test result ☐ Erroneous clinician interpretation of test
5. Assessment	☐ Failure/delay in considering correct diagnosis ☐ Suboptimal weighing/prioritizing ☐ Too much weight to lower probability/priority diagnosis ☐ Failure/delay to recognize/weigh urgency ☐ Failure/delay to recognize/weigh complications
6. Referral/Consultation	☐ Failure in ordering referral/calling consult ☐ Failure/delay in consult completion or obtaining/scheduling ordered referral ☐ Error in diagnostic consultation performance ☐ Failure/delayed communication/follow-up consultation
7. Follow-up	☐ Failure to refer patient to close/safe setting/monitoring ☐ Failure/delay in timely follow-up/rechecking of patient