The Joint Commission
Journal on Quality and Patient Safety®

The Safer Dx Checklist

10 Safety Recommendations to Address Diagnostic Errors

Reducing diagnostic errors (such as missed, delayed or wrong diagnoses) is a major challenge for healthcare organizations (HCOs) striving to improve patient safety.

A study featured in the November 2022 issue of *The Joint Commission Journal on Quality and Patient Safety (JQPS)* used a multimethod approach to develop a checklist of 10 high-priority safety practices HCOs can use to improve the safety of diagnostic processes and ensure infrastructure supports safe and timely diagnosis.

Researchers used a multistep procedure to **identify and select practices that could improve diagnostic safety** in real-world settings:

- Literature and reports by national and international organizations reviewed; quality/safety leaders interviewed
- Online Delphi expert panel of 28 experts identified 71 practices
- Multidisciplinary panel of 10 experts pinpointed 10 priority practices
- Chief quality and safety officers from three different types of HCOs conducted preimplementation review

"System interventions are most effective if they start at the top. If Dx errors are important to the leaders, they will be important to everyone."

—Delphi participant

"Without an accountability framework, we can identify problems but they never get fixed."

—Expert participant

"You will want someone who will have enough influence and power to make the board care about these things, but you also want the right experts to make sure the correct things happen, and the right processes are implemented."

—End user participant

The Safer Dx Checklist 10 High Priority Areas for Diagnostic Excellence

1
Organizational leadership builds a "board-to-bedside" accountability framework

2
A just culture and psychologically safe environment for diagnostic safety

3
Creation of feedback loops to increase information flow

4
Multidisciplinary perspectives, including cognitive science and human factors, in analysis of diagnostic safety events

5
Patient and family feedback to identify and understand diagnostic safety concerns

6
Patient review of their health records and mechanisms in place to help patients understand, interpret, and/or act upon diagnostic information

7
Prioritization of equity in diagnostic safety efforts by segmenting data to understand root causes and implementing strategies to address and narrow equity gaps

8
Standardized systems and processes to encourage direct, collaborative interactions between treating clinical teams and diagnostic specialties

9
Standardized systems and processes to ensure reliable communication of diagnostic information between care providers and with patients and families during handoffs and transitions

10
Standardized systems and processes to close the loop on communication and follow up on abnormal test results and referrals

The study shows that the Safer Dx Checklist can help organizations conduct a proactive, systematic assessment of risks to timely and accurate diagnosis and enable HCOs to begin implementing strategies to address diagnostic error.

To learn more about this study, visit:
https://www.jointcommissionjournal.com/article/S1553-7250(22)00180-5/fulltext

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