

• A DOSE OF INSIGHT®

HIDDEN IN PLAIN SIGHT

Exposing the Drivers of Diagnostic Error

A Three-Part Series:

Part Three: The Inpatient Setting

OCTOBER | 2026



COVERYS 

Q: WHAT CAN MALPRACTICE DATA TELL YOU ABOUT DIAGNOSTIC RISK? CONSIDER THE FOLLOWING QUESTIONS:

- Which inpatient settings are associated with the most diagnostic error claims?
- Which diagnoses are most often missed or delayed?
- What factors most frequently contribute to hospitalist-related diagnostic claims?

The answers to these questions will provide you with **valuable insight** that saves lives.

This white paper is the last in a series exploring diagnostic challenges in three different care settings.

Our first paper addressed diagnostic-related issues in the emergency department (ED)¹; the second examined errors and omissions in the office-based setting.²

In this white paper, you will learn:

- How often diagnostic errors occur in the inpatient setting, based on clinical analysis of professional malpractice liability event data
- Key factors that contribute to diagnostic error in the inpatient setting
- Practical recommendations to reduce diagnostic error
- How to identify vulnerabilities in your hospital through a data-driven self-assessment tool

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Coverys® evaluated 6,302 events that closed between January 1, 2021, and December 31, 2025, (excluding long-term and rehabilitation care) and identified 403 specific events where a diagnostic error in an inpatient setting occurred. Unless otherwise indicated, statistics and information in this publication were derived from this proprietary data.

CLINICAL CLAIMS ANALYSIS



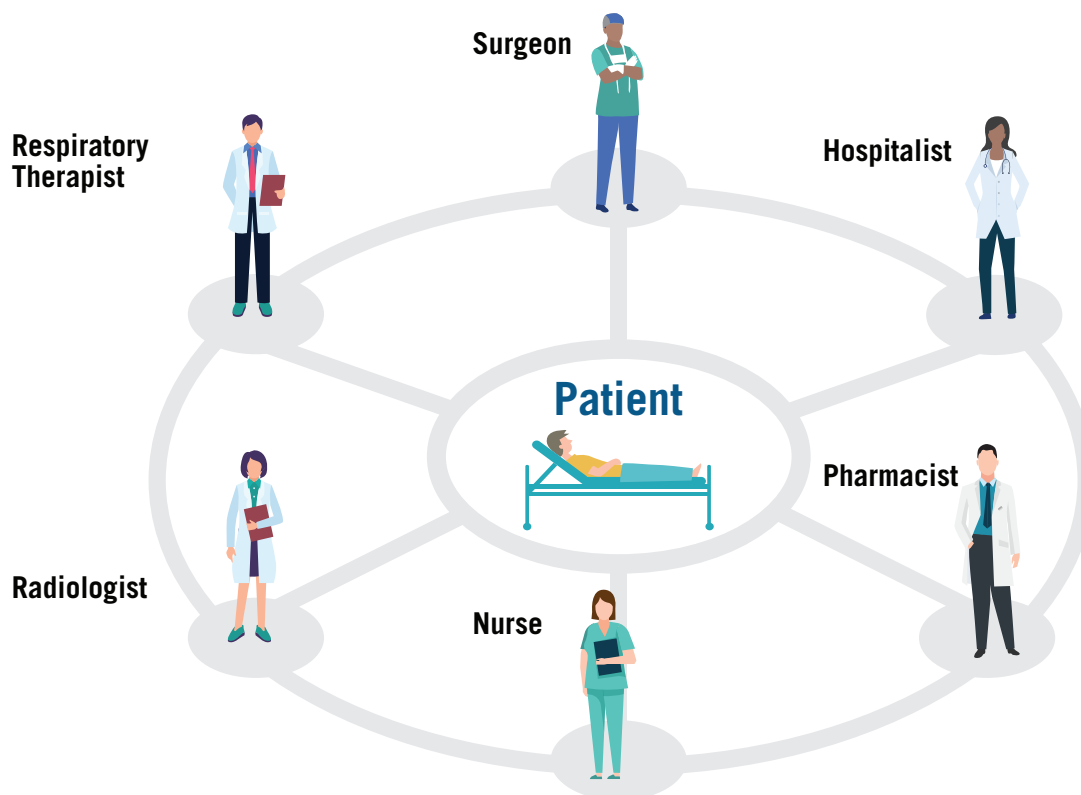
DATA METHODOLOGY

Medical malpractice clinical claims data is a rich source of information with which to build an understanding of diagnostic error and optimize systems that support diagnostic accuracy. Coverys employs a structured approach to collect and robustly analyze its closed claims data to provide critical insight into the drivers of error, harm, and claims.

Using a proprietary coding taxonomy, our team of expert clinical coders captures key data elements as they relate to the clinical encounter. Cases are coded at the “event” level, meaning all associated claims and suits are grouped into a single event. This approach provides a complete picture of the patient care journey, including all relevant healthcare professionals, both those named as defendants and those who played a role but are not named. By capturing multiple data points, we tell a comprehensive story of the patient’s care. This broad perspective enables organizations to better understand threats to diagnostic accuracy and provides actionable guidance to help identify and mitigate risk before harm occurs, ultimately improving patient safety.

It is important to understand for data clarity that, although it is common for inpatient admissions to originate in the ED, our analysis of the data confirms that the events associated with this study occurred during the inpatient stay and not as a result of the ED care.

CAPTURING MULTIPLE DATA POINTS ACROSS TIME AND PROVIDERS ENSURES A COMPLETE PICTURE OF THE PATIENT’S CARE JOURNEY



DIAGNOSTIC ERROR



PAST INITIATIVES AND PRESENT STATE

The Institute of Medicine (IOM) first described diagnostic error as a major patient safety issue in a 2015 report titled *Improving Diagnosis in Healthcare*. Diagnostic error is defined as a failure to establish an accurate diagnosis in a timely manner and to clearly communicate that information to the patient.³ In the years that followed, the understanding of diagnostic error has evolved from a narrow focus on the individuals involved to a broader view that diagnostic error prevention is best approached from a systems perspective. Many healthcare agencies, quality improvement organizations, and health systems have dedicated resources to eliminating this patient safety threat; yet, the problem persists.

This white paper's focus on the inpatient care setting provides a unique opportunity to add to the understanding of diagnostic error through the lens of medical professional liability (MPL) claims. **Robust analysis of this rich data source and critical review of the patterns and trends seen in these individual stories of patient harm create greater insights into the drivers of error and harm and shed light on the key vulnerabilities that contribute to diagnostic error.**

For most patients, admission to the hospital is a stressful event. They arrive frightened, sick, and overwhelmed and place their trust in strangers to determine what is wrong and how to help. Pain, uncertainty, and the unfamiliar hospital environment can leave vulnerable patients unable to question decisions or advocate for themselves. Instead, they rely almost entirely on the healthcare team to recognize the signs of illness, make sense of complex clinical information, and reach the correct diagnosis.

When that diagnosis is missed, delayed, or incorrect, the consequences extend far beyond a mere "error."

It can mean prolonged suffering, delayed treatment, or serious harm. It can also undermine the patient's trust at a time when trust is needed most.



800,000

people in the U.S. are estimated to die or become disabled due to diagnostic errors each year.³ The discovery by a patient or family that a consequential diagnosis was missed can raise both dread and anger, often expressed as, “How could you have missed this?”

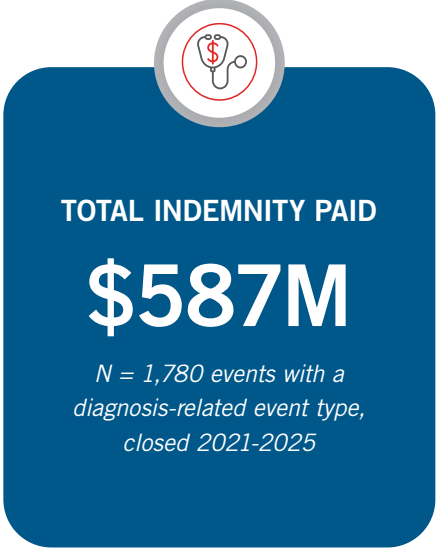
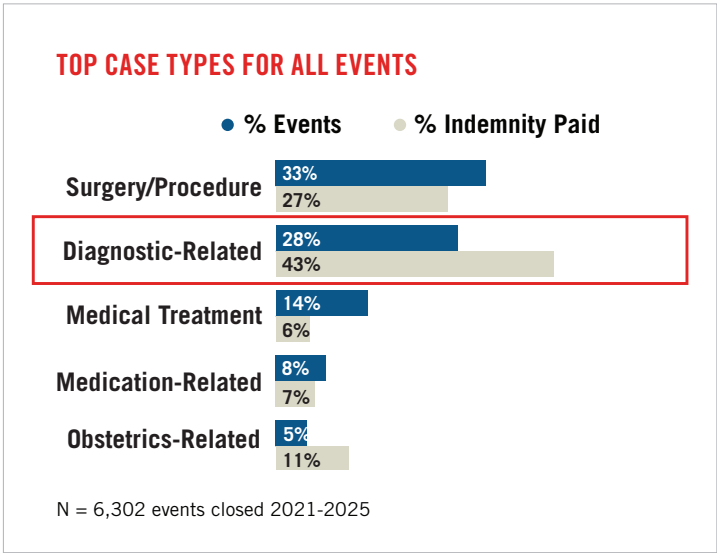


THE FINANCIAL IMPACT



THE COST OF DIAGNOSTIC ERROR

Diagnostic error isn't just a misstep—it's a costly mistake that can leave lasting harm for patients, their families, and the care teams involved. Coverys data identified that, although diagnostic error was the second most frequent event type, it was responsible for the highest percentage of indemnity payments across all settings.



Nuclear verdicts, commonly defined as jury verdicts of \$10 million or higher, have become increasingly common. Experts have theorized that this is driven by social inflation, normalization of higher costs, and public frustration with the corporatization of healthcare. Elevated jury awards may exceed insurance limits, increase premiums, and contribute to financial instability for institutions.

THE CONSEQUENCES



INPATIENT DIAGNOSTIC ERROR: BY THE NUMBERS

The data validates that diagnostic error continues to be a significant patient safety concern, not only due to **volume**, but also due to the **severity** of harm that occurs as a result of the error, frequently leading to permanent injury or death.

Injury severity definitions:

- HIGH:** Major and permanent injuries that result in loss of function.
- MEDIUM:** Injuries that can be resolved with a subsequent surgical procedure or medical treatment.
- LOW:** Injuries that are minor and may require additional treatment but have no complications or long-term physical effects.

Common myth:

There's a general belief that only the most severe events lead to claims. Our data reveals that across all malpractice case types, 61% of the events arise from cases with low- or medium-severity clinical outcomes.

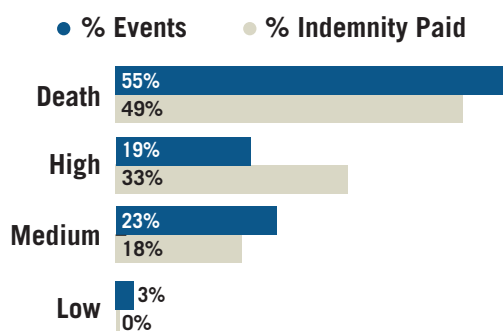
*6,302 events closed 2021-2025

What are the consequences?

The consequences of diagnostic error are devastating. Patients, their families, and clinical care teams are physically, emotionally, and/or professionally harmed—in many cases, suffering heartbreaking losses. More than 50% of all of the diagnostic-related events in the inpatient setting resulted in a patient death.

The financial impact creates significant burden for healthcare professionals and the healthcare system at large. **Indemnity payments for inpatient diagnostic events are greater than all other events combined.** These payments were, on average, approximately 17% higher than those associated with other inpatient event categories.

CLINICAL SEVERITY



N = 403 events with a diagnosis-related event type in the inpatient setting, closed 2021-2025

AVERAGE INPATIENT INDEMNITY PAID

Diagnostic-Related

\$623K

N = 403 events with a diagnosis-related event type in the inpatient setting, closed 2021-2025

Non-Diagnostic-Related

\$534K

N = 1,911 events with non-diagnosis-related event type in the inpatient setting, closed 2021-2025

CRITICAL FINDINGS



INSIGHTS FROM INPATIENT EVENTS

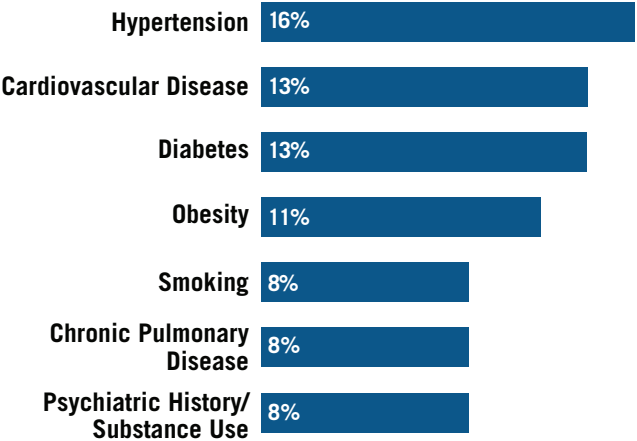
The Influence of Patient Comorbidities

A key critical finding in this study is the significant impact of comorbidities on the diagnostic process. In more than 75% of the inpatient diagnostic events, the patient had one or more comorbidities. Almost half of all Americans have hypertension⁴ and/or cardiovascular disease.⁵ Comorbidities can obscure the diagnostic picture, leaving clinicians with multiple potential explanations to consider in the differential diagnosis. In these situations, prioritizing diagnostic testing and reviewing results promptly is imperative to avoid delays in appropriate treatment and prevent patient harm. As the complexity of a patient’s medical history increases, so does the complexity of the diagnostic process, requiring careful clinical judgment and ongoing reassessment to identify the correct diagnosis.

Diagnostic Danger Zone: Medical-Surgical Units

Analysis of the data revealed another important trend—the vast majority of inpatient events occurred in the Medical-Surgical Unit. Patients in critical care units have the highest acuity and severity of illness, and an assumption can be made that their risk for diagnostic error would be higher, but that is not what the data showed. The environment and staffing models of critical care and general inpatient units differ significantly. Patients in critical care settings are typically in direct view of staff and undergo continuous monitoring. In contrast, patients in lower-acuity units are often less visible to staff and less likely to be continuously monitored. As a result, recognition of clinical deterioration frequently depends on a healthcare professional entering the patient’s room and identifying changes. The accompanying clinical case summaries highlight the critical role of ongoing assessment and timely, effective communication of status changes to physicians.

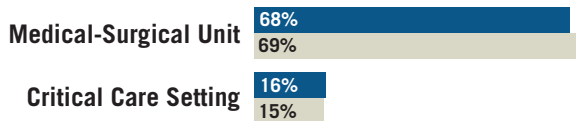
TOP COMORBIDITIES*



309 of the 403 events closed 2021-2025 with a diagnosis-related event type in the inpatient setting had one or more comorbidities

*An event can have more than one comorbidity

TOP CARE SETTINGS



N = 403 events with a diagnosis-related event type in the inpatient setting, closed 2021-2025

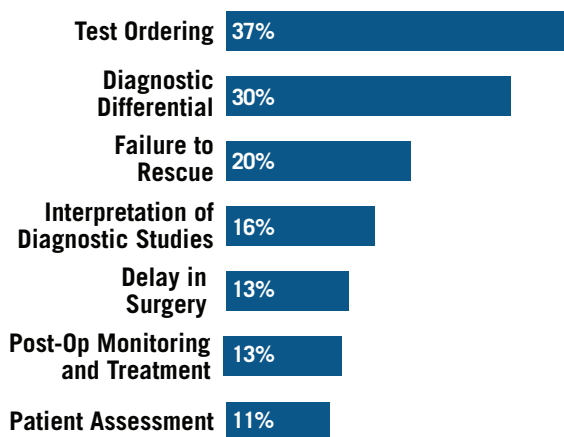
KEY VULNERABILITIES



CLINICAL DECISION-MAKING

The diagnostic process is iterative in nature; it is more than an initial label applied to a group of symptoms. Clinicians gather information and, using clinical reasoning to guide decisions, generate a differential diagnostic list. As new information becomes available, the diagnosis is refined. Each step of the process uses information gathered earlier; if one step is flawed, a cascade of missteps can follow. **More than 90% of diagnosis-related events were impacted by a risk factor that contributes to clinical reasoning.**

KEY VULNERABILITIES IN CLINICAL DECISION-MAKING*



364 of the 403 closed events from 2021-2025 had one or more risk factors contributing to clinical decision-making in diagnosis-related cases in the inpatient setting

*An event can have more than one risk issue

THE IMPACT OF COGNITIVE BIAS

Cognitive bias has been determined to contribute to diagnostic error events. Cognitive bias refers to systemic errors in reasoning, which affect the ability of the clinician to collect data, interpret findings, direct treatment, and assess outcomes.

Two common types of cognitive bias are:

- **Anchoring bias.** The tendency to perceptually lock on to salient features of the patient's initial presentation too early in the diagnostic process.
- **Confirmation bias.** Looking for confirming evidence to support a diagnosis rather than disconfirming evidence to refute it.

Of the 364 events with one or more risk factors impacting clinical decision-making:

- **Test management issues were identified in greater than 50% of all inpatient diagnostic errors.** This includes test ordering and test interpretation.
- **In 30% of the events, clinicians failed to create a wide diagnostic differential.** Cognitive bias can contribute to a clinician's narrow focus.
- **Failure to rescue was identified in 20% of the 364 events in this category.**

Hospitals must ensure there are systems in place to support the diagnostic process. Removing the stigma of cognitive bias—recognizing that everyone has it—is an important first step in creating psychological safety to express diagnostic uncertainty. When patients are not responding as expected to the treatment or symptoms don't align on a specific diagnosis, diagnostic time-outs can move the diagnostic process into a more analytical framework that allows clinicians to safely ask, "What are we missing?" and, "Could bias be at play here?"

TOP CLINICAL SERVICES



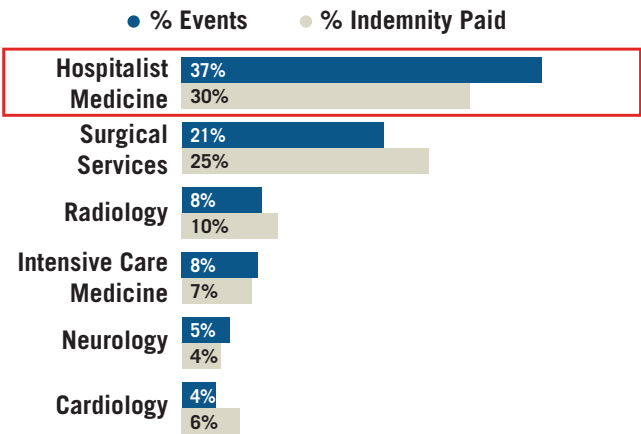
INPATIENT CLINICAL SERVICES: HOSPITALIST MEDICINE

Identifying the services most frequently involved in specific types of events allows an organization to focus its performance improvement activities on those areas most vulnerable to these issues.

Given that many hospitals either employ or contract with hospitalists to manage inpatient care, it is not unexpected that this group was associated with a greater number of inpatient diagnostic events. Total indemnity costs associated with hospitalist activities were also higher, accounting for 30% of the total payout. Importantly, **more than 76% of the hospitalist-related events resulted in death or a high-severity injury and accordingly accounted for 87% of the indemnity burden.**

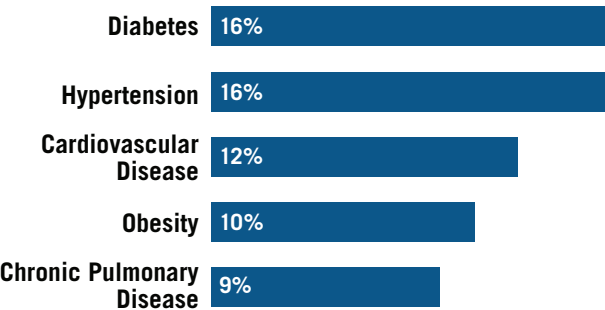
Further data analysis revealed that a significant number of patients assigned to the hospitalist service had high-acuity conditions and multiple comorbidities. Preexisting conditions contribute to the complexity of patient presentation and care, thereby creating diagnostic difficulty. Symptoms may be incorrectly attributed to an existing condition, or clinicians may fail to recognize subtle changes in acutely ill patients. These changes can be an important signal of a new acute condition requiring further evaluation.

TOP CLINICAL SERVICES



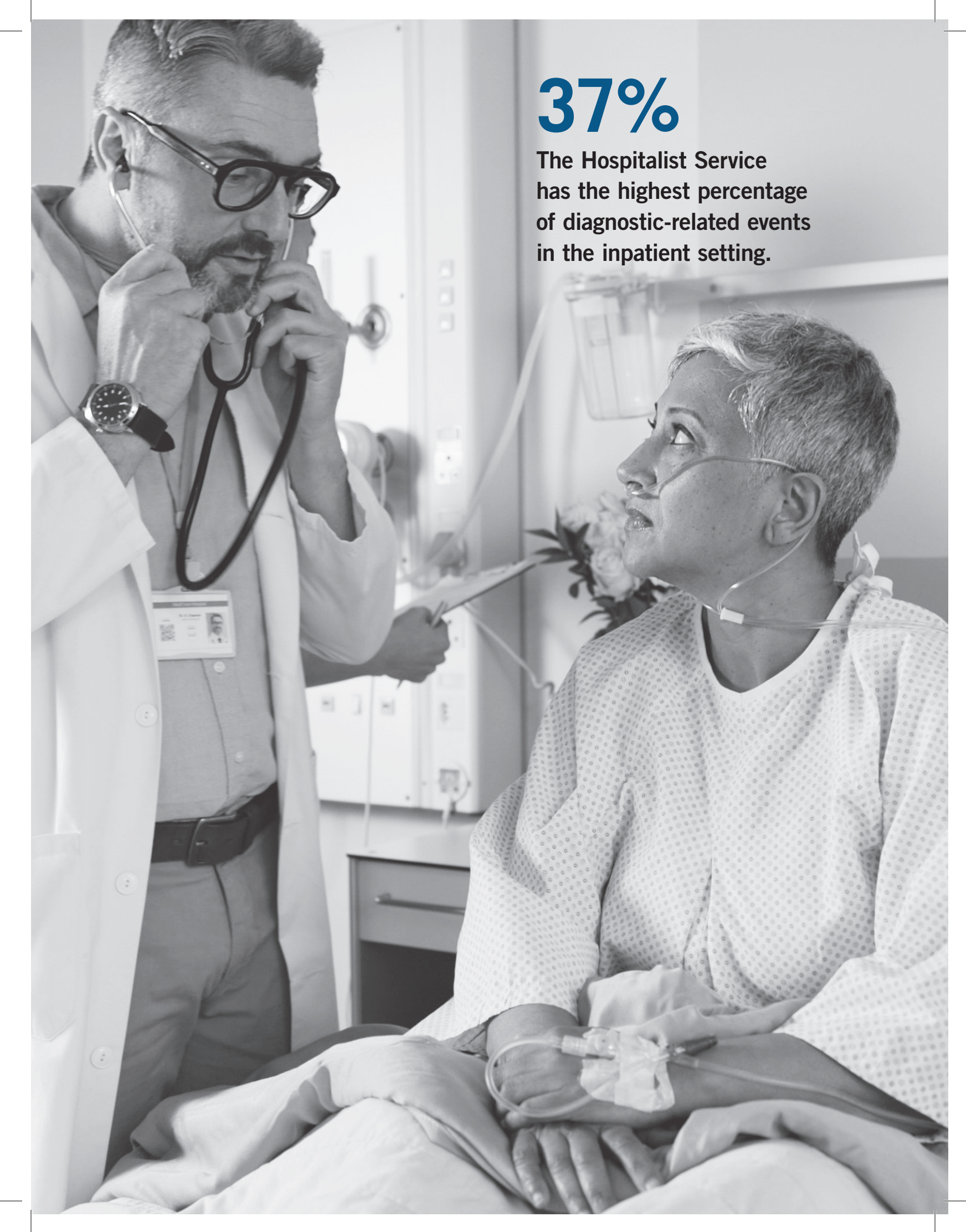
N = 403 events with a diagnosis-related event type in the inpatient setting, closed 2021-2025

TOP COMORBIDITIES*



125 of the 150 events closed 2021-2025 with a diagnosis-related event type, inpatient setting, and hospitalist service had one or more comorbidities

*An event can have more than one comorbidity



37%

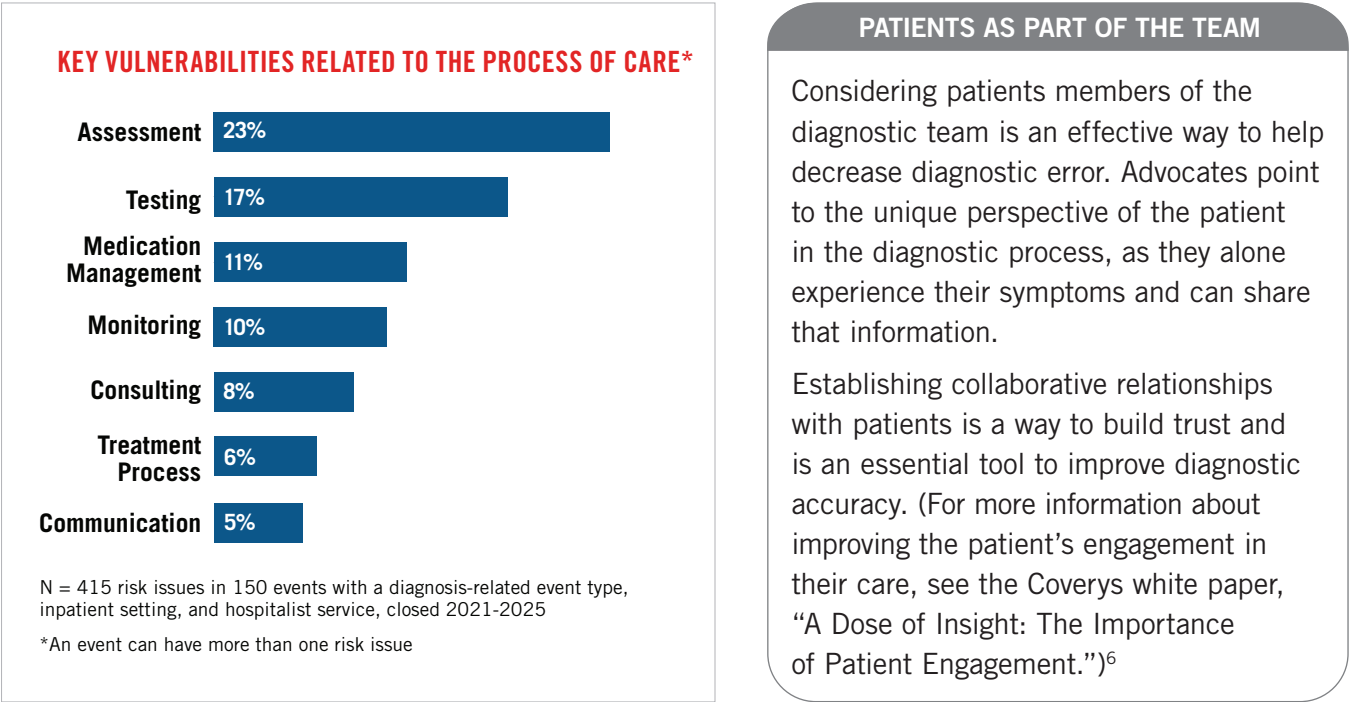
The Hospitalist Service
has the highest percentage
of diagnostic-related events
in the inpatient setting.

PROCESS OF CARE



KEY VULNERABILITIES RELATED TO HOSPITALIST CARE

Although individual patient factors played a role in the events, a deeper analysis of the data identified key risk factors within the process of care that affected the diagnostic outcome.



PATIENT ASSESSMENT IS KEY: Data revealed that, in many cases, there was a failure to fully appreciate the patient’s overall condition, including symptoms, history, and comorbidities, during the diagnostic assessment.

APPROPRIATE MANAGEMENT OF PATIENT TESTING: The diagnostic process relies on accurate and timely data, with the results of clinical testing supplying critical information. When relevant testing is omitted or is not ordered with the appropriate level of urgency, diagnostic errors can ensue. If testing results are not reviewed in a timely manner, diagnostic delays can occur.

CASE SUMMARY: FAILURE TO FACTOR THE PATIENT'S REPEATED REPORTS OF CONTINUED SYMPTOMS INTO THE WORKING DIAGNOSIS LED TO DEATH.



A woman in her mid-40s with chronic pain managed by an intrathecal medication pump was hospitalized for severe back pain, urinary incontinence, and leukocytosis. A magnetic resonance imaging (MRI) scan showed nonspecific findings, but the radiologist advised clinical correlation, noting that the study was limited by motion. Although a spinal infection was initially considered, the hospitalist became concerned about possible drug-seeking or psychogenic causes when symptoms seemed inconsistent with findings. Despite the patient's repeated reports that her symptoms were worsening and felt different from her baseline chronic pain, her concerns were not meaningfully incorporated into the team's diagnostic assessment.

The patient was transferred to rehabilitation, where she continued to report numbness and weakness. Weeks later, imaging revealed a thoracic vertebral lesion, and a neurologist ultimately diagnosed a catheter tip granuloma causing spinal cord compression. By the time surgery was performed, she had developed permanent paraplegia and later died from sepsis related to pressure ulcers.

“The patient and family are often the most important—and most overlooked—source of clinical data. I know this personally: Two members of my family were harmed by diagnostic errors after I raised concerns and reported symptoms that should have informed immediate action. When we fail to listen to patients and families, critical diagnostic information might be missed. In diagnostic safety, listening to the patient and family can be the difference between recognizing risk and rescuing too late.”



SUE SHERIDAN, MIM, MBA, DHL
FOUNDING MEMBER/PRESIDENT AND CEO
PATIENTS FOR PATIENT SAFETY US

TOP MISSED DIAGNOSTIC CATEGORIES



INPATIENT CLINICAL SERVICES: HOSPITALIST MEDICINE

Crucial Misses

The Coverys data identified that vascular conditions and infections were by far the most common missed diagnoses in hospitalist medicine claims. Given the potential for rapid deterioration in these scenarios, a miss or delay can result in a significant impact on the severity of harm and patient outcome.

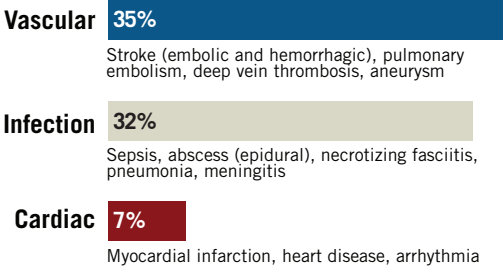
Trends in Misdiagnosis of Vascular Conditions

Analysis of the data revealed common missteps in the process of care that led to the correct diagnosis being missed or delayed. Subtle symptoms of vascular conditions may be initially thought to be related to other causes, such as the effect of medication or sedation.

A deeper look at the data related to vascular injuries reveals that the key contributors involve delayed test ordering, narrow diagnostic focus, and delay in ordering medication, resulting in failure to rescue.

Vascular injuries often result in a higher severity of patient harm, as illustrated by the data. When minutes matter, opportunities are lost to initiate treatment when a clinical change is noted, and this leads to more severe injury to the patient.

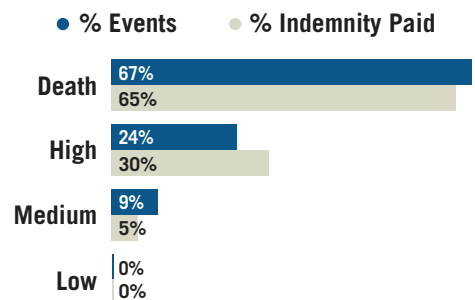
TOP MISSED DIAGNOSTIC CATEGORIES*



N = 161 missed diagnoses in 150 events with a diagnosis-related event type, inpatient setting, and hospitalist service, closed 2021-2025

*An event can have more than one missed diagnosis

CLINICAL SEVERITY OF VASCULAR CONDITIONS



N = 55 events with a diagnosis-related event type, inpatient setting, hospitalist service, and a vascular injury, closed 2021-2025

Trends in Misdiagnosis of Infections

Interestingly, the drivers for diagnostic misses of infections were similar to those associated with the misdiagnosis of vascular conditions. The contributing factors for infection-related events include:

- Narrow diagnostic focus
- Absent or delayed testing
- Failure to act in a timely manner
- Delay in ordering medications (antibiotics)

The data validates the importance of timely assessment, monitoring, and response to a patient's changing status by broadening the diagnostic differential, ordering indicated testing, and treating promptly with the correct medications.

DIAGNOSIS IS A TEAM SPORT

Clinical pharmacists can be essential members of the diagnostic team, particularly when treating patients with infections. They help direct systemwide protocols to guide clinicians in ordering testing and treatment when infections are suspected and assist in choosing appropriate tests and medication for individual patients.

CASE SUMMARY: COULD ADDING A CLINICAL PHARMACIST TO THE INPATIENT DIAGNOSTIC TEAM CONTRIBUTE TO A BETTER OUTCOME?



A patient with chronic leukemia and on immunosuppressive therapy presented with fever and altered mental status after recent pneumonia. He was admitted with presumed sepsis and treated with broad-spectrum antibiotics, but his condition worsened.

A lumbar puncture and computed tomography (CT) scan suggested infection and possible infarcts, while an electroencephalogram (EEG) indicated encephalopathy. After the patient experienced seizures and was transferred to critical care, an MRI scan revealed multiple brain abscesses.

Biopsy confirmed fungal encephalitis, but the diagnosis came too late, and the patient died.

The family filed a claim, alleging the hospitalists failed to consider the patient's significant risk for a fungal infection, given his immunosuppressive treatment with ibrutinib, which delayed accurate diagnosis and timely intervention.

TOP CLINICAL SERVICES

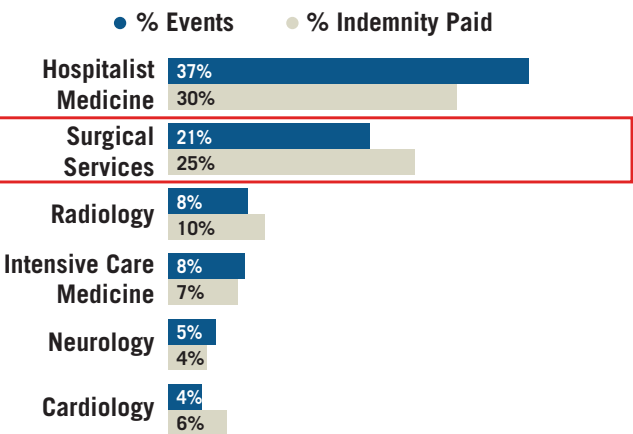


INPATIENT CLINICAL SERVICES:
SURGICAL SERVICES

Surgical patients represent a uniquely vulnerable population when it comes to diagnostic error because their conditions are often complex due to the interplay between their recent procedure, underlying comorbidities, and the possibility of evolving postoperative complications. Symptoms such as pain, fever, swelling, or changes in vital signs may be attributed to the expected recovery process, making it more difficult to recognize early signs of a surgical complication.

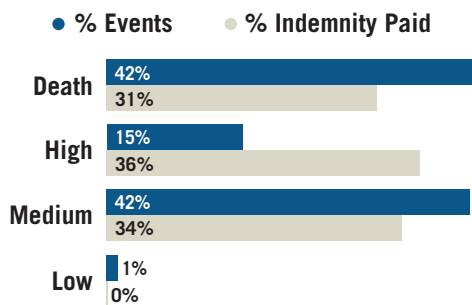
Indemnity levels are largely driven by the severity of patient harm, and events involving missed or delayed diagnoses for surgical patients frequently resulted in significant clinical consequences. Delays in recognizing conditions can lead to disease progression, the need for more extensive treatment, permanent injury, or death. As a result, claims associated with missed or delayed diagnoses for surgical patients often carry substantially higher indemnity payments than other types of events, reflecting the serious patient outcomes and long-term impacts that can occur when timely intervention is not provided.

TOP CLINICAL SERVICES

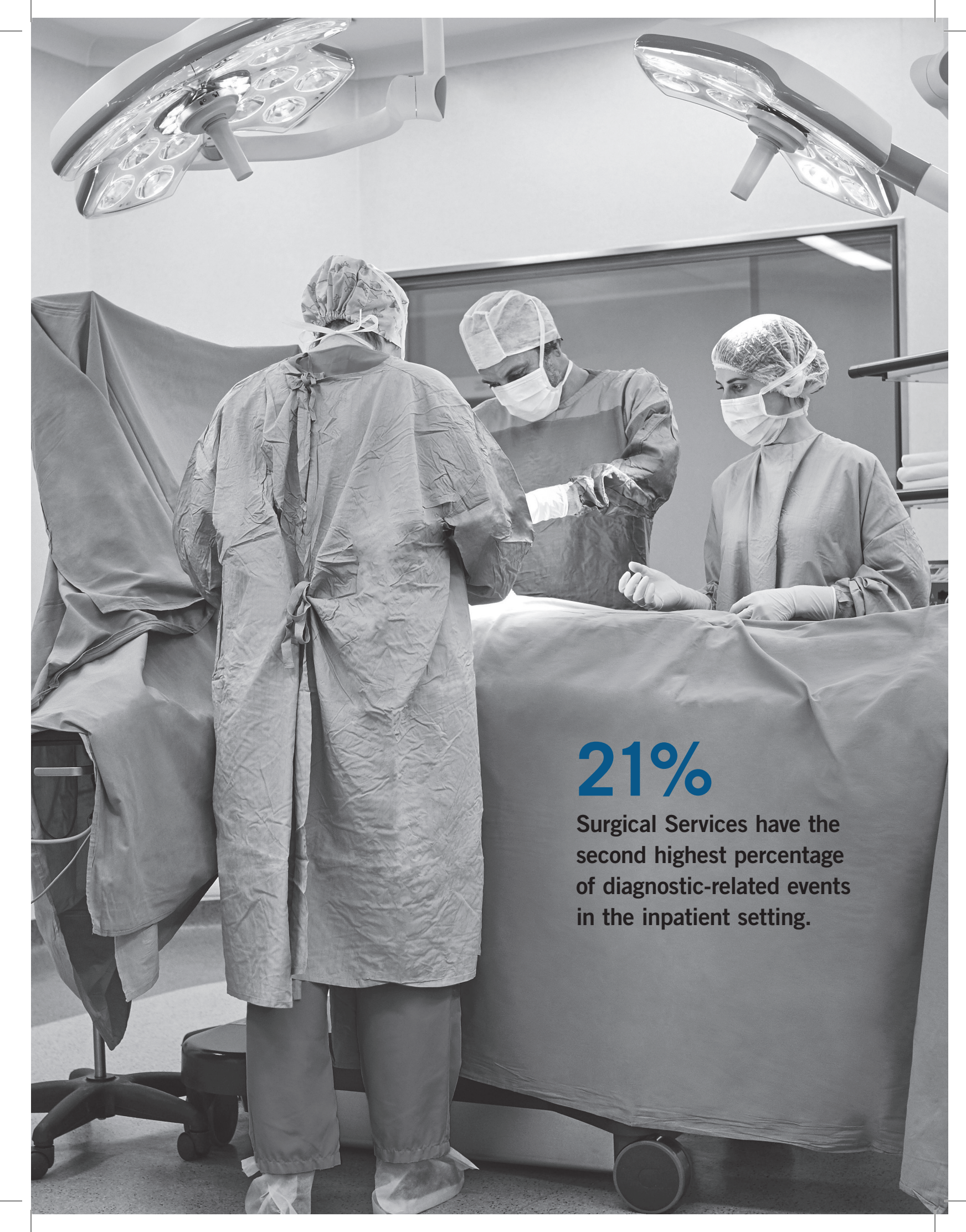


N = 403 events with a diagnosis-related event type in the inpatient setting, closed 2021-2025

CLINICAL SEVERITY



N = 84 events with a diagnosis-related event type, inpatient setting, and surgical service, closed 2021-2025



21%

Surgical Services have the second highest percentage of diagnostic-related events in the inpatient setting.

DIAGNOSTIC ERROR



KEY VULNERABILITIES RELATED TO SURGICAL CARE

Surgical diagnosis-related event data highlights recurring process-of-care vulnerabilities that affected diagnostic outcomes.



ASSESSMENT 19%

Missed history details, narrow differentials, incomplete reassessment, or premature discharge



MONITORING 17%

Patients were not consistently monitored or treated after procedures, contributing to delayed responses to evolving or declining symptoms



TESTING 17%

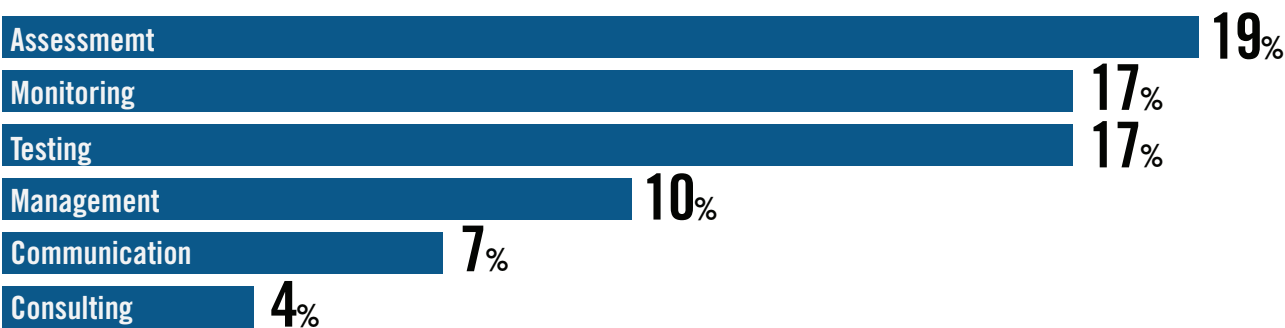
Tests were not ordered, results were inaccurately interpreted, or results were inappropriately routed to wrong provider



MANAGEMENT 10%

Overall management of the surgical patient including issues related to comorbidities and medication

RISK ISSUES BY PROCESS-OF-CARE CATEGORY*



N = 227 risk issues across 84 diagnosis-related events in inpatient surgical services, closed 2021–2025
An event can have more than one risk issue

THE PRACTICE IMPROVEMENT OPPORTUNITY

Strengthen assessment, test management, monitoring, and timely response to clinical changes across the surgical care process

CASE SUMMARY: HOW POOR COMMUNICATION AND NARROW DIAGNOSTIC FOCUS CAN HAVE A SERIOUS IMPACT ON PATIENT CARE.



A patient was admitted to critical care for pneumonia and septic shock. He required intubation and the administration of three intravenous medications for blood pressure support. An arterial line was placed in the right femoral artery. Several hours later, nursing noted pallor to the right lower extremity and absent pulses.

An angiogram confirmed a common femoral artery thrombus and occlusion. The intensivist ordered a consult with a vascular surgeon. The team initiated treatment, which included an infusion of a tissue plasminogen activator as part of a catheter-directed pharmacomechanical thrombolysis intervention. Despite these efforts, the patient developed compartment syndrome. This led to a four-compartment fasciotomy of the leg, during which the surgeon discovered a dissection of the femoral artery, likely a complication from the arterial line placement. Several days later, the patient required an above-the-knee amputation.

At no point in the care process was a dissected artery considered as the cause of the pulseless leg, assuming the ischemia was from the pressors being administered. Deposition testimony noted that none of the physicians were aware of the progression of the ischemia, although the registered nurse (RN) documented that this information had been communicated.



Coordination and communication among team members are critical to an effective, patient-centered diagnostic process.

Using structured communication tools during handoffs helps ensure that critical and relevant information is shared. This helps improve the diagnostic process by enhancing clarity and helping staff to correctly interpret clinical changes that may signal complications.

TOP MISSED DIAGNOSTIC CATEGORIES



INPATIENT CLINICAL SERVICES: SURGICAL SERVICES

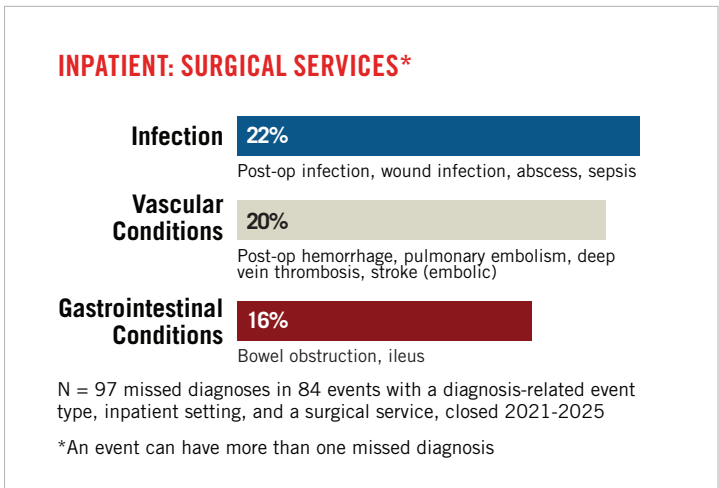
Crucial Misses

The data identifies that infections and vascular conditions are the most likely groups of diagnoses missed by surgeons, similar to the data for the hospitalists. Gastrointestinal conditions were the third most frequently missed diagnostic category by surgeons. The graph below identifies the most commonly missed specific diagnoses within each category. Importantly, a delay in diagnosis for any of these complications is problematic, as treatment is time-sensitive, with patient outcomes negatively affected by delayed initiation of interventions.

Infection-Related Diagnostic Events in Surgical Patients

Data pertaining to infection-related surgical diagnostic errors identifies the importance of ordering the right test, at the right time, which was a primary finding in the analysis of the hospitalist-associated events. Given that hospitalists and surgeons frequently share responsibility for managing postoperative patients, it is not surprising that the factors contributing to diagnostic delays and missed diagnoses overlap across both groups.

The data revealed several key trends in surgical patients with delayed or missed infection-related diagnoses:



- **Failure to order** laboratory tests and imaging studies at the appropriate time
- **Failure to promptly adjust therapy** for postoperative patients based on testing results, specifically when ensuring that ordered antibiotic therapy was correctly matched to the identified organism cultured
- **Failure to monitor** patients for signs of deterioration and consider whether the patient was developing sepsis
- **Delay in requesting consultations** with other specialists to manage infections
- **Delay in returning** the patient to surgery for exploration or an additional procedure



Vascular-Related Diagnostic Events in Surgical Patients

Analysis of the data related to misdiagnosed vascular events identified concerns with clinical reasoning including:

- **Anchoring** on the patient's comorbidity instead of recognizing worsening symptoms as evidence of a complication
- **Failure to monitor** patients for signs of deterioration
- **Failure to timely order** studies that could supply critical and necessary information
- **Patient discharge** without evaluation and recognition of signs of clinical instability

Diagnosis-Related Gastrointestinal Complications in Surgical Patients

The data identified misdiagnosed gastrointestinal complications in over 15% of the events; bowel obstruction and ileus were the most frequently missed due to:

- **Failure or delay** to reassess
- **Failure or delay** to order additional indicated testing
- **Delay in addressing** the cause of constipation proved significant in some events and led to intestinal perforation



Focusing on key vulnerabilities and the most frequently missed diagnoses can significantly reduce the frequency of diagnostic error.

Continuous clinical reassessment is an essential practice to improve diagnostic accuracy.

SELF-ASSESSMENT TOOL



IDENTIFYING YOUR VULNERABILITIES

Our analysis of inpatient malpractice events uncovered vulnerabilities that contribute to diagnostic error and harm. The following self-assessment identifies crucial best practices that address the contributing factors in our data. How consistently does your team follow the recommendations in each of the following areas?

History & physical (H&P) and test ordering: Complete and timely information for full assessment.

Always Sometimes Unsure

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| ☐ | ☐ | ☐ | Our H&P process ensures clinicians update all clinical information relevant to the patient's current or evolving complaint—including comorbidities and pertinent family history—using input from the patient, family, other providers, and medical records when appropriate. |
| ☐ | ☐ | ☐ | Our team communicates sufficient clinical data to consulting providers , including clinical pharmacists, to support focused diagnostic reasoning, appropriate test selection, and timely treatment recommendations. |
| ☐ | ☐ | ☐ | We have standardized definitions for test urgency (STAT, urgent, routine), which includes expected turnaround times and a defined process for reporting critical test results. |
| ☐ | ☐ | ☐ | We follow a standardized process to communicate, review, and act on test results . |

Diagnostic processing and differential: Workflows and team structure that support accurate information synthesis.

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| ☐ | ☐ | ☐ | Our team recognizes the potential impact of cognitive bias on the diagnostic process and is comfortable raising concerns about such pitfalls as anchoring bias or cognitive bias. |
| ☐ | ☐ | ☐ | Our team uses a diagnostic time-out or similar process to review all data and perspectives before a final diagnosis or discharge decision is made. |
| ☐ | ☐ | ☐ | We have optimized the use of decision support tools to assist with test selection and to aid in the development of an all-inclusive diagnostic differential list. |
| ☐ | ☐ | ☐ | We include patients and families in the diagnostic process through patient- and family-centered rounds, shared decision-making, and other collaborative communication methods whenever feasible. |

Ongoing monitoring: Consistent reassessment and escalation for change/decline in status.

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| ☐ | ☐ | ☐ | We have a standardized process for monitoring and communicating repeat vital signs and other risk-based clinical data. |
| ☐ | ☐ | ☐ | Our team uses structured tools and standardized processes to identify trends or early signs of decline or decompensation. |
| ☐ | ☐ | ☐ | We have a defined practice for communicating and escalating any change in patient status, lack of expected treatment response, and/or signs of clinical decompensation. |
| ☐ | ☐ | ☐ | We have a process for capturing, reviewing, and learning from failure-to-rescue events to support ongoing process improvement . |

Safety culture, teamwork, and communication: Robust safety culture and effective communication among the care team.

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| ☐ | ☐ | ☐ | We utilize a structured process for handoff communication to ensure that crucial clinical findings are communicated, feedback loops are closed, and gaps in accountability are avoided. |
| ☐ | ☐ | ☐ | Our team communicates diagnostic uncertainty clearly and explicitly, so care team members understand what is known, what remains unclear, and what follow-up is needed to refine the diagnosis. |
| ☐ | ☐ | ☐ | We document pertinent clinical communication including key conversations, consultant recommendations, diagnostic reasoning, and follow-up plans in the medical record, including information obtained through non-traditional channels, such as secure chat or text. |
| ☐ | ☐ | ☐ | We foster a strong culture of safety, teamwork , and communication in which team members—regardless of role, discipline, or setting—feel empowered to speak up, identify diagnostic red flags, and escalate patient safety concerns. |

LEADING CHANGE



COVERYS DATA-INFORMED METHODOLOGY FOR ACTION

Using insights revealed by the self-assessment tool, your team can expose the hidden drivers of diagnostic error in your hospital-based practice and take action to eliminate them; this is the foundational methodology behind our data-driven approach.

Leading this change will involve identifying your organization's unique vulnerabilities and implementing new protocols. It will require the commitment of the entire care team to work together to implement solutions with consistent monitoring, continual adjustments, and ongoing vigilance.

While this effort won't be easy, it will be worthwhile. When you eliminate the drivers of diagnostic error, you will reduce the harm experienced by patients, their loved ones, and their care teams. You will also help mitigate the trend of exorbitant medical practice liability costs and thermonuclear verdicts—and their impact on the ever-increasing cost of healthcare.

Five Key Steps

1

RAISE AWARENESS

Share this report to educate your team on the prevalence of diagnostic error, its causes, and how it can be prevented.

2

KNOW YOUR DATA

Become a data sleuth. Ask for a review of your adverse event, patient experience, and culture safety data. Set measurable goals for improvement.

3

ENLIST AND ENGAGE

Develop champions to vigilantly lead change, continually improving your most vulnerable areas.

4

EVALUATE AND MONITOR

Stay on track, monitoring and sustaining best practices and holding teams accountable.

5

CONTINUOUSLY ADAPT

Continuously adapt your practices to address emerging exposures. Monitor metrics to avoid complacency.

INSURANCE PRODUCTS & SERVICES TO SUPPORT HEALTHCARE

You can count on Coverys for comprehensive insurance coverage and leading-edge services to help you improve clinical, operational, and financial outcomes—so you can focus on patients.

RiskRx PRO is a comprehensive service solution providing clinical risk mitigation and claims resolution services for Coverys medical professional liability (MPL) insurance policyholders.

Risk Mitigation Services

- Data-informed clinical insights of risk and vulnerabilities
- Expert consultation
- Risk & culture of safety assessments
- Targeted world-class education powered by Coverys and Med-IQ®
- Robust 24/7 resources



Claims Management & Resolution

- Claims de-escalation support
- Personalized litigation and expert claim support
- Collaboration with premier defense attorneys
- Expert claims professionals with deep experience advocating for our insureds
- Compassionate support from a team that understands the personal impact of litigation

Thought Leadership



For the latest in thought leadership and risk mitigation strategies, visit our Expert Insights page on [Coverys.com](https://www.coverys.com).

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Case summaries and other patient examples shared in this publication are derived from actual malpractice claims with identifying details removed or altered to protect the anonymity of patients, families, healthcare providers, and healthcare organizations. The information in this report is intended to provide general guidelines for risk management. It is not intended as, nor should it be construed as, legal or medical advice.

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