

Failure modes and effects analysis (FMEA)

Project: **Code Green In-Patient Unit Process**

Date: **6/13,6/23, 6/29, 7/20, 7/25, 8/2, 10/12, 12/29, 2/13**

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SEV = How severe is effect on the customer?
 OCC = How frequent is the cause likely to occur?
 DET = How probable is detection of cause?

RPN = Risk priority number in order to rank concerns; calculated as SEV x OCC x DET

Process step	Potential failure mode	Potential failure effects	SEV	Potential causes	OCC	Current process controls	DET	RPN	Actions recommended	Responsibility (target date)	Actions taken	NEW	NEWC	NEWT	NEWN
What is the step?	In what ways can the step go wrong?	What is the impact on the customer if the failure mode is not prevented or corrected?	10	What causes the step to go wrong? (i.e., How could the failure mode occur?)	10	What are the existing controls that either prevent the failure mode from occurring or detect it should it occur?	10	1000	What are the actions for reducing the occurrence of the cause or for improving its detection? You should provide actions on all high RPNs and on severity ratings of 9 or 10.	Who is responsible for the recommended action? What date should it be completed by?	What were the actions implemented? Include completion month/year (then recalculate resulting RPN).	10	10	10	1000
Behavior	Warning Signs not identified	Code called before de-escalating attempted; increased pt/staff injury; decreased pt dignity;	9	lack of training; patient location and staff assignment; failure to provide important information (inappropriate handoff communication); subjective interpretation of warning signs	9	Training; SBARQ; Nursing Assessment; Experience, Education	10	810	Education; Power Point Presentation (live/video) EAM Training	Rose Ann Moore Brian Sarpy	Rose Ann Moore will create Power Point Presentation for education to be completed by December 31, 2011. 10/12 Brian Sarpy reported that 10 individuals have received the training education from CPI. Meeting to be scheduled to discuss roll-out of education to staff.	9	5	5	225
	De-escalation attempts not successful	more labor intensive; decreased productivity; decreased pt satisfaction; disrupts all pt care; delay in appropriate pt care				Training; SBARQ; Nursing Assessment; Experience, Education	10	810	Education; Power Point Presentation (live/video) EAM Training			9	5	5	225
	Correct Patient Placement					Guidelines; processes; night & weekend supervisors	9	729	Education; flow diagram, review of process			9	3	3	81
	Failure of accurate and pertinent handoff communication					SBARQ Auditing; SBARQ Committee	10	810	Education; Power Point Presentation (live/video) EAM Training			9	8	9	648
Alarm	Initially call wrong number	Delay in response; potential increase injury to pt/staff; increase chance for reportable event	8	lack of training; staff anxiety; unable to hear alarm (lack of reporting issues); speaker logistics;	9	Training	2	144	None	Rose Ann Moore	Rose Ann Moore will include information in her Power Point Presentation.	8	2	2	32
	lack of speakers / decreased volume					Logistics; Cost	2	144	None			8	5	2	80
	Give OPS inaccurate info					Training	5	360	None			8	2	1	16
Response	Untrained Responders Arrive	Decreased patient and staff satisfaction; increased potential injury; unnecessary physical contact; increased chance for reportable event; lack of direction	10	Lack of Training; Security Staffing	8	Training	8	640	Update process; re-define	Group will discuss after final approval or disapproval of education changes	Pending discussion and management decision about staff education (CPI) CPI training may cover many of these issues.	10	8	7	560
	Too Few / Too Many Responders						7	560	Update process; re-define			10	3	1	30
	No identified "Lead" Person to report to					Training; Protocol	10	800	Update process; re-define			10	7	3	210
	Desensitivity to alarm sounds						1	80	None			10	8	1	80
	Timeliness of security response					Protocols	6	480	None			10	8	6	480
Cancel Code	Process to cancel code (who can call)	Waste of resources; lost productivity; potential patient dissatisfaction	3	Protocol	5	Policy & Procedures	6	90	None	Rose Ann Moore	Rose Ann Moore will have slide in Power Point Presentation to cover this area.	3	3	6	54
Follow-Up	Debriefings (#of and quality)	loss of knowledge; failure to follow policy; failure to follow action plan; decreased ability to improve process; inability to identify trend(s) and implement appropriate corrective action(s)	10	Education, Culture, Time	10	Policy & Procedures	8	800	Revise debriefing form; re-educate	Heidi Baird	Heidi Baird will review and update debriefing form as needed. Risk Management will forward a copy of all debriefing forms that they receive to be reviewed.	10	8	4	320
	Analysis of Debriefings						10	1000	Report data to patient safety; Director of Support Services to forward reports to Regulatory. Risk Management to forward debriefing forms to Regulatory			9	6	5	270