Failure Mode & Effect Analysis (FMEA)

Potential failure mode	Resultant Problem	Possible Action Steps
1. Patient not assigned to same inpatient team for each admission.	Discontinuity	Work with Admitting/Residency Office: Readmit to same physician team Readmit to same nursing team/unit Talk with Administration regarding ways to work with problem patients, i.e. in ER, problem patients are readmitted to the same nursing unit
2. Incomplete information on transfer between services	Poor communication and poor follow-up care	Co-authors on discharge summary Standardize transfer summary
3. Too many people involved in discharge decision	Prolonged hospitalization	Develop process to streamline voices instead of eliminating them Electronic check-out form to coordinate discharge readiness decision Need correct information and patient knowledge
4. Too many people involved in discharge notification: Chaotic, repetitive process with various gaps Excludes any input from patient regarding their perceived readiness for discharge	Everyone involved in patient care is not always informed of discharge decision; no patient "voice", no say in discharge care which can lead to inappropriate placement; delays in discharge process	Create centralized electronic service for communication Develop appropriate, clear assignment/delineation of responsibilities On centralized electronic form, clarify who's responsible with checklist as each team member completes components they are responsible for Discharge coordinators can serve as liaison between patient and various providers of patient care
5. When making PCP follow-up appointment, no one checks with patient to see if time is convenient/possible	No appointment New system is having patient schedule their own appointment if they're able	Patients not capable, need quick appointment, etc Coordination between unit clerk and patient regarding availability/ability to make appointment All appointments to be made other than by patient, are made by unit clerk Dedicated schedulers to make follow-up appointments efficiently Give coupon, go to "schedulers", and make all appointments before leaving With access to computing systems to ACC and other outpatient clinics to make appointments directly Laptops available to make appointment process more efficient Have office on inpatient floor to schedule appointments
6. Support services not set up Currently, all VNA referrals are done by CM	Readmission	VNA personnel are based here at BMC and write notes in chart: Include VNA personnel in discharge meetings Conduct routine follow-up (from hospital to home) phone calls within 48-72 hours • Have dedicated person to follow-up - "long term case management" Get people involved in the process who knew patient prior to hospitalization Provide Boston HealthNet PCP's incentive to be involved in this process Incentive to physicians (PCP) to see patients within 5 days of discharge Required PCP notification of hospitalization-at admission and discharge Electronic links of notification to PCP Get all health centers on Logician (electronic, outpatient, medical record)

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7. Lack of appropriate training regarding components of discharge paperwork and responsibility of each component/step in the process	Discharge summary not complete or not correct	Shift responsibility for discharge summary/paperwork from interns to residents • Include appropriate training for interns and residents clarifying whose role each component is • Automating the process and discharge summary will help with this shift of responsibility since lots of work will automatically be completed by transferring information/data from one area of system to the discharge summary
8. Patients leave hospital without prescriptions (meds) Discharge medications: – if changes are made during hospitalization, are these changes incorporated into discharge instructions by nursing team? – confusion between admission and discharge medication (reconciliation) duplications/gaps Nursing team not notified regarding changes in medications/prescriptions at discharge	No medications; wrong medications given to patient at discharge; wrong medications taken by patient upon discharge; delay in discharge process	Med Teach – provide training on how to use this Prescriptions computer linked to outpatient pharmacy (VA does this now) Develop contact at pharmacy, both inpatient and outpatient Have prescriptions filled and delivered to nursing team Conduct patient education with actual medications, pillbox filled Have designated window at pharmacy for hospital discharges Have pharmacy involved in patient education Add "changes from admission" section on discharge summary with details regarding admit and discharge medications and notes regarding all changes made during hospitalization
9. Too many people involved in patient education but not assigned or defined to a particular role and therefore no one accountable for the outcome	Patient gets mixed messages while discharge education is either missing or incomplete	Make someone responsible for patient education
10. There is not time for patient education	Patient education either missing or not complete	More in-service training regarding patient education Allow time for this!
11. No clear mandate/system for discharge education No system to identify degree of need for discharge education so education can be tailored Patient education and literacy not adjusted according to patient's level of literacy/health literacy Patient education about disease is not part of discharge	Poor patient discharge education, lack of patient understanding of disease, treatment, and follow-up care	Assign some type of responsibility for which patients: • need/require patient education • what type of patient education would be best suited • assess patient's literacy level and tailor education to that level, electronic checklist can help with this • develop "education sheet" as part of electronic hospitalization – documents
12. No discharge plan given to patient Patient not told about pending lab/tests Literacy level of patient medication sheets too high	Lack of understanding of what to do next Missed appointment, lab not followed up Patients don't understand medications	Develop Discharge Plan for each patient which includes: Information regarding inpatient hospitalization All changes in medications with clear details regarding what and how to take upon discharge clear follow-up instructions for patients written at a level that patient can read and understand regarding appointments, nutrition, exercise, lifestyle changes, when to follow-up with PCP, etc.
13. When does the discharge process start? In order to have timely discharge, often rushed at end when much detail needed	Rushed discharge causes errors	Involve Emergency Department in discharge process: Begin on-line data collection and discharge planning form in ED and have linked to inpatient record and/or discharge summary paperwork Include section on discharge plan with details of significant psychosocial issues that have led to admission
14. No in-service on how to do discharge	Incomplete discharge	Quarterly reviews for interns and attendings, nursing personnel, and other providers as needed

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15. PCP unaware of hospitalization and issues during inpatient stay and outstanding issues upon discharge	Poor follow-up by PCP	Link computerized records to Logician and autofax of discharge summary to outside physicians Dedicated discharge personnel to work with PCP
16. Patients cannot get medications from pharmacy days/nights/weekends	Patients don't get medications	Organize system to get medication to patients upon discharge
17. No standard process for who gets narcotics	No consistent policy about discharge medications	Create centralized narcotics registry/database
18. Many assumptions about who does what but lack of accountability	No checklist or toolbox or patient discharge "guru"	Need centralized discharge facilitator
19. No follow-up with patient post-discharge, "did you get medications, etc?"	No medications // implement 48-72 hour pharmacy telephone call	Follow-up by member of inpatient staff within 48 – 72 hours
20. No auditing system for discharge processes	No improvement	Linked to item #37 – person can track outcomes/issues identified
21. No organized way to get discharge resume to PCP	PCP lack of info	Should be automated
22. No system of sending labs/tests to PCP (pending labs/tests)	Lack of follow up of labs	Should be automated
23. Medical mistakes	No process to discuss and fix	Increase ease of error reporting with formal review