FMEA 2010- "To Establish Effective Communication To Provide Patient Centered Care"

Potential Failure Mode/ Process or (Primary Cause) for Communication Breakdown	Sub-Processes or Secondary & Tertiary Causes	Frequency of Occurrence	Severity	Detectability	RPN * Criticality Index (FxSxD)	Priority Position by the RPN	Process Redesign/ Recommended Action Plan (should be designed in the FMEA meeting)/Solution and Referral Committees
1. Communication in Health Care & at UHB	A. Hand-off communication	4	4	4	64	**7**	Standardized practice of SBAR. Electronic Health Record will be able to provide the update continuously and if the level of care changes.
	B. All Diagnostic and Medical Orders	5	2	5	50	**10**	Electronic communication of ordering and result of the test. Currently available in Health Bridge and Cerner.
	C. Reporting Diagnostic Results	3	2	5	30	**12**	Timely communication of test result. Currently available in Health Bridge and Cerner. Critical Result policy in place.
	D. ER Med Intranet based Program	3	2	4	24	**14**	T-system and Health Bridge should be interfaced as the admitting team takes over the patient care from ED.
2. Expectation from the Leadership	A. UHB's Mission , Vision, Values & Practice of TJC's standards	3	5	2	30	**12**	Routine reinforcement of existing standards. Define it to the staff level. Employee hand out is in place.
	B. Practice of Six Pillars of Excellence (People, service, quality, community, finance & growth)	3	4	2	24	**14**	Interdisciplinary practice is ongoing. Different interdisciplinary teams are applying the core values.
	C. Periodic Web based or Microphone Message for frontline staff regarding Practice Essentials	7	5	2	70	**6**	Should have a broad based system in all areas of facilities. On-site and off-sites.
	D. Utilization of Employee Need to Know Hand book	5	4	2	40	**11**	Department of Regulatory Affairs updates and communicates the information to the staff.

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3. Escalation Process	A. Attending to Attending & all Interdisciplinary communication process	5	9	2	90	**3**	Medical Executive Committee and Medical Director ensures the process through the ongoing professional practice evaluation. Chain of command cascade is in place.
	B. Lack of Culture for Escalation (early activation criteria)	4	8	2	64	**7**	Organizational policy and protocol is in place. Interdisciplinary group evaluate the program.
	C. Staff Availability & Accessibility to the policies	4	6	3	72	**5**	There is a intranet based web site WWW.UHB.ORG/PNP. Hard to navigate. Dept. of Regulatory Affairs may provide a help line.
	D. Team STEPPS & simulation training	4	3	5	60	**8**	There is an interdisciplinary team is in the process of hospital wide implementation of this TEAM STEPPS program.
	E. Intimidation and fears	2	7	2	28	**13**	Staff is encouraged to communicate their concerns to their supervisors and to the appropriate disciplines. Ongoing survey for the staff remarks can address this issue proactively.

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4. Roles, Responsibilities & Accountability	A. Employee skill sets & limitation in moving the process forward	6	8	2	96	**2**	New employee orientation with the updated programs. On going continuous education program and mandatory training for the all employees.
	B. Inconsistency in training, education and reeducation	6	7	2	84	**4**	ICL (Institute of Continuous Learning) is updating the curriculum with the interdisciplinary input and professional development program. Critical Thinking and Knowledge Transfer forum. Service Excellence Council.
	C. Staff feedback	2	7	4	56	**9**	Periodic staff Satisfaction survey and Culture of Safety survey.
	D. Leadership & Management development program	4	7	3	84	**4**	Organization wide education program and orientation. Supervisor's training program.
	E. Information Technology Development & Involvement	5	7	3	105	**1**	Health Bridge Committee, Information Systems sub-committee, Health Information Management committee, IS dept. Implementation of CPOE & EHR is ongoing.

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5. Lack of Common Language for Situational Awareness	A. Infectious Disease approval for Medications	2	7	2	28	**13**	Division of Infectious Disease provide the protocol and service. Communication should be adequate at all level. Prescriber & ID fellow should communicate with each other before prescribing. Pharmacy & Nursing should be updated with any changes accordingly.
	B. Continuous update of Medical Record	5	6	3	90	**3**	Department of Medical Record and Professional Staff must communicate with each other on time to complete all the medical record. Electronic Health Record will make the process efficient.
	C. Early Activation Criteria	4	8	2	64	**7**	The early activation criteria is established. Continuous follow up.
	D. Overhead Telecommunication as needed	7	5	2	70	**6**	All important messages should be communicated at a regular interval through a centralized communication system.
	E. No Primary Care Provider during Discharge	4	6	3	72	**5**	The Ambulatory service and Hospital administration are evaluating the following programs, i.e., the patients with no PCP care can have a hospital appointed Primary care provider/ physician (PCP) service and anticoagulation follow up service at Coumadin clinic, etc.

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	F. Availability and accessibility of timely OPD visits for the discharged pts	4	6	3	72	**5**	The Ambulatory service and Hospital administration are evaluating the clinic appointment system and programs for PCP service, follow up visit at Coumadin clinic, etc.