## Failure Mode & Effect Analysis (FMEA)

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<tr>
<th>Potential failure mode</th>
<th>Resultant Problem</th>
<th>Possible Action Steps</th>
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| 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)                                | 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                                   | 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                                               | 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 |
<p>| 14. No in-service on how to do discharge                                              | Incomplete discharge                                                            | Quarterly reviews for interns and attendings, nursing personnel, and other providers as needed |</p>
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<td>15. PCP unaware of hospitalization and issues during inpatient stay and outstanding issues upon discharge</td>
<td>Poor follow-up by PCP</td>
<td>Link computerized records to Logician and autofax of discharge summary to outside physicians &lt;br&gt; Dedicated discharge personnel to work with PCP</td>
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<td>16. Patients cannot get medications from pharmacy days/nights/weekends</td>
<td>Patients don’t get medications</td>
<td>Organize system to get medication to patients upon discharge</td>
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<td>17. No standard process for who gets narcotics</td>
<td>No consistent policy about discharge medications</td>
<td>Create centralized narcotics registry/database</td>
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<td>18. Many assumptions about who does what but lack of accountability</td>
<td>No checklist or toolbox or patient discharge “guru”</td>
<td>Need centralized discharge facilitator</td>
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<td>19. No follow-up with patient post-discharge, “did you get medications, etc?”</td>
<td>No medications // implement 48-72 hour pharmacy telephone call</td>
<td>Follow-up by member of inpatient staff within 48 – 72 hours</td>
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<td>20. No auditing system for discharge processes</td>
<td>No improvement</td>
<td>Linked to item #37 – person can track outcomes/issues identified</td>
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<td>21. No organized way to get discharge resume to PCP</td>
<td>PCP lack of info</td>
<td>Should be automated</td>
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<td>22. No system of sending labs/tests to PCP (pending labs/tests)</td>
<td>Lack of follow up of labs</td>
<td>Should be automated</td>
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<td>23. Medical mistakes</td>
<td>No process to discuss and fix</td>
<td>Increase ease of error reporting with formal review</td>
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