Failure Mode Effective Analysis -Case Study

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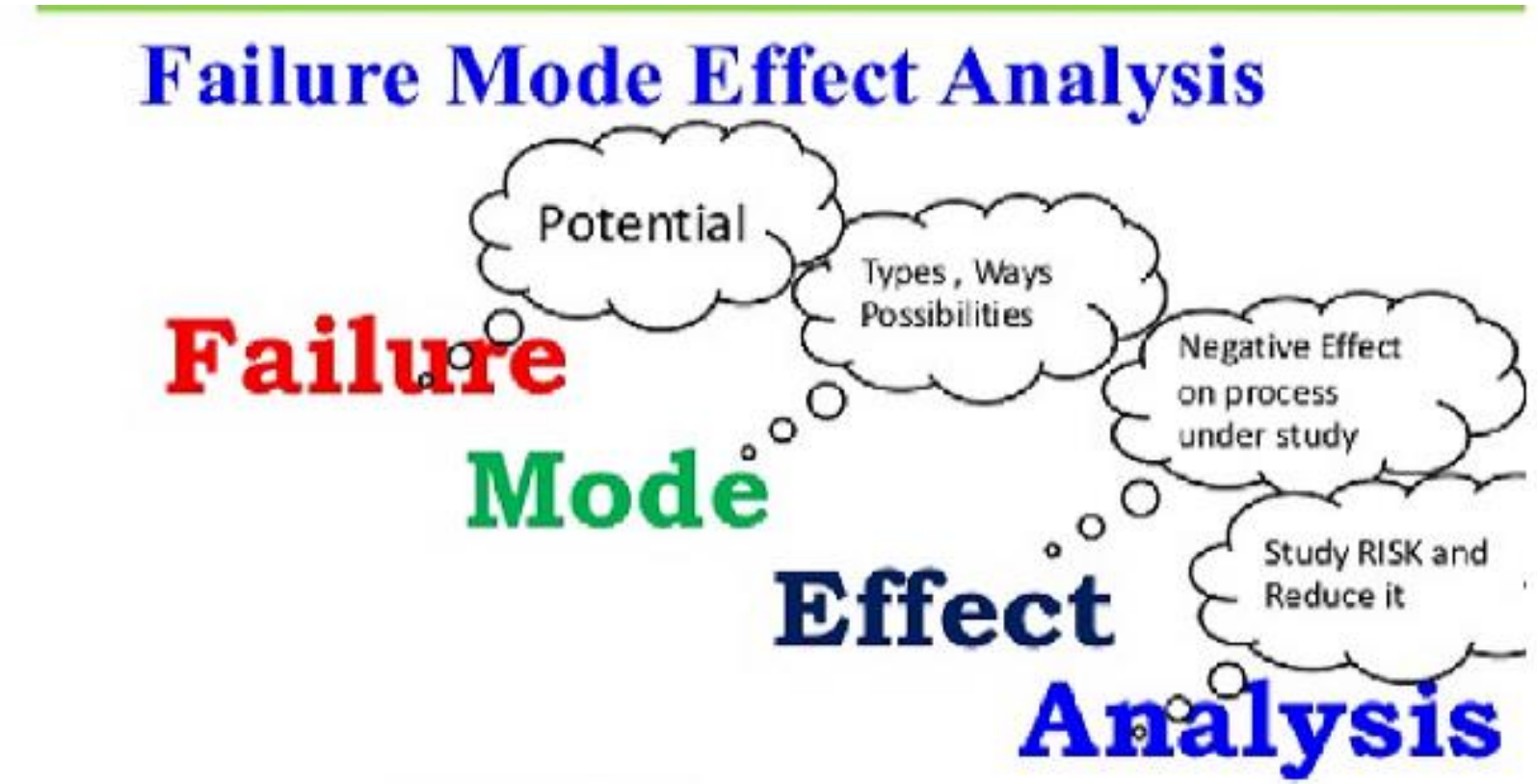
DESCRIPTION

- Infant abduction in hospital X since 1995-145 cases
- Average births per month-300
- Abduction occurring at the post natal ward
- No banding system of infants
- Inadequate training of security staff

FMEA

Healthcare Failure Mode and Effects Analysis is a process used to identify potential failures and their causes before future services are provided.



PROCESS

1. Define the Topic
   Scope of the project with a clear definition of the process selected
2. Assemble a Functional Team
   Team must be multidisciplinary
3. Describe the Process
   Create a Process Flow Chart or Diagram
4. Brainstorm potential failures, modes, causes and effects
5. Create an action plan
6. Determine Actions and Outcome Measures
   Closure of the issue is expected

DEFINE THE TOPIC

- Minimize the potential abduction in Hospital X

ASSEMBLE THE TEAM

The Team must comprise of

- Quality managers
- Doctors
- Nursing supervisor
- Staff nurse
- Security supervisors
- Group D supervisors

SL NO	FAILURE MODE	CAUSE	EFFECT
1.	Banding of infants • Bands not taken into OR/Labour room • Incorrect ID • Infant not banded	• Bands left back due to emergency • Multiple births at one time • No proper SOP and Standard of care	• New born sent to ward without the band • Infant given to wrong mother • Can lead to abduction and wrong baby with wrong mother
2.	Lack of wrist code system for infants	• staff not aware of the importance of the band • Unable to track if new-born is present or abducted • Failure of alarm system	• Potential cause for abduction • Infant not secure
3.	New born information not entered in the system	• Work load issues • Multiple births	• New born being misplaced
4.	Code pink	• Unaware of the code pink protocol	• Delay in tracking the infant • Child abduction will be quick
5.	Issuing attender pass without adequate details	• Misuse of the pass by different attenders • Security unaware of details written in the pass	• Wrong attender to wrong baby • Chance of abduction increases
6.	Inadequate trained security and nursing personnel	• SOP's not known	• New-born not treated effectively • Abduction chances increase

ACTION PLAN

- Policy Up Gradation
- Risk Analysis by Marking the Severity, Occurrence and Detectibilty and Calculate RPN
- Training of Nursing staff and security staff
- Regular code pink drills and staff training on alarm systems
- Prepare checklists
- Access control is essential
- Police surveillance in case of abduction
- Education of family and relatives
- Adequate verification at the time of discharge

THANK YOU