



Failure Mode Effects Analysis for 2008

Patient Identification



FMEA Steps

- Identify process steps
- What can fail in each step & current likelihood of occurrence (2a)
- Effect of the failure & seriousness of risk when failure occurs (3a)
- Cause of failure & probability of detection (4a)
- Risk Priority number = $2a \times 3a \times 4a$



Patient ID - FMEA

- March 2008
- Patient Units, Clinics, PCA, Registration, Diagnostics, PDS, “Fix Team”, Patient Safety, ED, Risk, Quality
- Update in November 2008



Broad Process Steps

- Pre-registration *
- Registration & Check in *
- Correction of information *
- ID Banding & Re-banding *
- Specimen collection
- Procedures *



Broad Process Steps continued

- Interventions (meds, transfusion)
- Orders and Requisitions
- Testing
- Record scanning



System Causes of Failure

1. Pre-registration, Registration & data correction
 - Multiple ports of entry for patients
 - Standards for Reg/ADT unclear
 - Orientation/training differed with ports of entry
 - Lack of understanding about trickle down of data corrections
 - Perceived issues related to “Doe” usage
 - Scroll & Click user function
 - Intentional ID fraud by patient



Actions #1

- Registration Error PI started
- Registration Standards updated & staff re-training initiated
- Quality Audits started
- Pilot started for KC Jail inmates where pictures are scanned in sent to HMC
- Organizational changes brought registration (ports) under on Division



System Causes of Failure

2. Patient banding & Re-banding
 - Access to bands for re-banding
 - Label standard inconsistencies b/w Reg/ADT & Epic
 - APOP not specific enough
 - Need for banding in OP unclear
 - Transfusion sample tied to Doe



Actions #2

- APOP revised to address order of limb to band
- Radiology now banding all CT patient with plan to band all
- Sub-group addressing standardization of system labels.
- Work with Anesthesia/OR to re-place bands removed during surgery



System Causes of Failure

3. Procedures (universal protocol)
 - Lack of understanding of protocol outside the OR
 - Team shared mental model of protocol & roles
 - Lack of documentation of protocol



Actions #2

- Sub-committee work on Universal Protocol
- Team STEPPS committee in development will address team shared mental models/practices
- Procedures power form in development for ORCA (nurses)