

**FMEA Falls Assessment- Sample Hospital, December 2004**

<i>Processes and Subprocesses</i>	<i>Failure Modes (what might happen)</i>	<i>Causes (why it happens)</i>	<i>Effects</i>	<i>Severity/probability/Hazard score</i>	<i>Actions to Reduce Failure Mode</i>
Falls Screen	Delay in performing screen	Staffing, emergencies	Patient may fall prior to screen being performed.	3X2=6	
	Inaccurate or incomplete information	Patient unable to communicate, gives incorrect information, family unavailable. Patient unavailable (in surgery, xray, etc)	Incorrect assignment of risk factor or no assignment of risk factor.	3X4=12	Modify procedure to incorporate family input, input from nursing home. Stress importance of past history, nurse tech input.
	Patient types not assessed- ED and outpatients	Not in current policy	Patients may fall.	2X4=8	Refer to ED Administration.
	Staff does not prioritize. Staff not aware of potential hazard of falls.	Unaware of hazards for patients	Patient may fall.	3X4=12	Emphasize the importance of timely screening and falls risk score assignment in education on procedure changes. The current policy limits falls prevention and assessment to nursing. During revision process, incorporate input from and roles

						<b>for PT, Pharmacy, EVS, Maintenance, and Physicians. Policy should be a Hospital Policy. Utilize unit bulletin boards to post information.</b>
	Medications not assessed, including changes or additions.	Not currently included in policy	Staff unaware at times of impact of medications on LOC and mobility.	3X4=12		Add section to procedure for assessing medications with input from Pharmacy.
	Mobility assessment not performed adequately.	Staffing. Staff awareness of importance.	Incorrect risk score may be assigned leading to a fall.	3X3=9		Revise section F in procedure to be more comprehensive. Have Physical Therapy input in procedure in development.

**Action Plan:**

Since there is significant overlap between the processes and subprocesses and the failure modes, we have outlined a specific action plan focusing on the areas with the highest hazard scores. All processes and subprocesses will be reviewed during the policy revision and educational sessions conducted after the policy revision.

1. Benchmark with other organizations to determine best practices. Special interest will be focused on screening and risk scoring tools and screening related to effects of medication. Assigned to \_\_\_\_\_. Target date for completion \_\_\_\_\_.
2. Investigate whether the Meditech system will automatically flag patients at high risk of falls once the falls score is entered. Assigned to \_\_\_\_\_. Target date for completion \_\_\_\_\_.
3. Request nurse tech input every shift into the falls risk screening. Consider changing routines to allow nurse techs to enter information in their handheld relating to falls risk and appropriate interventions. Assign to group working on #6.

4. Investigate options for clear identification of patients at risk for falls. Consider using a large colored dot or other distinct symbol that will be easy to visualize. Assign to group working on #6.
5. Develop systematic method for communicating with the patient care nurse regarding medication changes. The psychiatric unit has a system in place. Assign to \_\_\_\_\_. Target date \_\_\_\_\_.
6. Revise the Falls Risk Screening and Falls Prevention plan. Emphasize the need for proactive preventive measures. The system currently is reactive, not proactive. Assign to Clinical Educators. Target date \_\_\_\_\_.
7. The team will present the FMEA to the Hospital PI Committee at the January 26, 2005 meeting. QM Manager will review the FMEA with the Executive staff prior to January 26, 2005.