

Failure Modes and Effects Analysis (FMEA) Worksheet – SAMPLE

FMEA Process Steps

Step 1: Define the scope and the process to be studied (select a high-risk process):

Include your rationale for the high-risk topic and your completed decision tree analysis:

Check all that apply:

□ Near misses have identified the potential for risk issues that may impact patient safety

- □ Internal data and/or occurrences reveal frequency or severity for topic chosen
- External data indicate frequency or severity for topic chosen
- □ A new system, process, procedure and/or technology is being introduced

Other – explain:

Note: Attach data (run charts, control charts, etc.) that support the rationale for the high-risk topic selection (as applicable).

Conduct the FMEA under the quality oversight process and document the FMEA information in the quality committee minutes.

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Decision Tree

Use the decision tree to ensure that the high-risk area is proper selection for an FMEA topic.



Adapted from: VA National Center for Patient Safety (NCPS), "The Basics of Healthcare Failure Mode and Effect Analysis." Available at

http://www.patientsafety.va.gov/professionals/onthejob/hfmea.asp, 06/17/2016.

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Step 2: Identify the multidisciplinary team members (maximum of 10-12 team members).

Area of Expertise	Unit/Dept/Company	Person's Name
1. Subject matter expert		
2. FMEA leader		
3. FMEA facilitator		
4. FMEA recorder		
5.		
6.		
7.		
8.		
9.		
10.		

- Step 3: List the information needed to conduct the FMEA process.
 - a. List the internal procedures, guidelines and protocols specific to the subject matter.



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C.	List results of literature searches for standards/best practices.	
d.	List the professional organizations/societies for resources.	
e.	Staff members/department personnel to interview regarding the process.	
Step 4: Pro	ocess Map – Identify area/process to be mapped out.	

Map current practice Map standard practice according to "best practice/comparative practice" Map practice in accordance with your internal procedures

(Attach maps)

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Step 5: Hazard Analysis – List the failure modes for the process steps and sub-process steps under study. Assess failure modes and identify causes and effects.

(Attach FMEA table)

- 5a) Determine hazard analysis score: severity x probability = criticality
- 5b) Determine detectability: Use decision tree on failure modes.
- Step 6: Prioritize failure modes for action based on criticality score.
- Step 7: Identify risk treatment, actions, follow-up measures and person accountable; include a timeline.
- Step 8: Test the redesigned process and implement, if effective.
- Step 9: Monitor the effectiveness of the redesigned process.
- Step 10: Maintain the effectiveness through spot checks.
- Step 11: Report activity and results to the quality oversight committee.

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