Theme: Patient Safety (Jan 1, 2016, to June 30, 2016)

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1. **The rationale for Selection:** Infant abduction is defined as the kidnapping of an infant between birth and six months of age by a non-family member. According to NMEC (The National Center for Missing & Exploited Children), 308 infants were abducted from 1983-2016. However, 12 still missing and not reached to correct family. In 2015, at The Aga Khan Secondary Hospitals, 2 near misses has been reported which reflect non-compliances of the define policies and procedures of safe discharge of neonate. Therefore, QPSD proposed to do FMEA to do in-depth risk assessment and implementation of strategies for identified gaps of the existing system from Jan to june2016.
2. **Relevance to Quality & Safety Policy and/or Vision/Mission/Core Values of the institution:** Our quality policy states that we should provide companionate, ethical, and high-quality care that meets the need for our patient and to others to whom we serve.
3. **Project Mission or Goals:** The project aimed to identify areas of opportunities, to do in -depth analysis of the process, designing action plans, execution of plans by the implementation of strategies followed by sustainable Plans and strategies. The goal is **ZERO** sentinel events & Near Misses due to unsafe infant safety process.

4. **Team Composition:** Multidisciplinary team including Administration, Nursing, and Security, Led by QPSD team.
5. **Data Collection Methodology:** Team conducted on-site risk assessments at the 4 Secondary hospitals to identify an area of opportunities for improvement via FMEA Methodology. FMEA can help identify and eliminate concerns early in the development of a process or new service delivery. It is a systematic way to examine a process prospectively for possible ways in which failure can occur, and then to redesign the processes so that the new model eliminates the possibility of failure.
6. **Use of Quality Improvement Tools:** Risk Assessment Matrix has been using as a tool to assess the processes based on 6Ms (Men, Machine, Method, Measurement, Material and Motherhood and used standard FMEA framework.
7. **Structural Organization of the project**: As a tool embedded within Six Sigma methodology DMAIC (Define, Measure, Analyze, Improve, Control) Project Tool was used to examine a process prospectively for possible ways in which failure can occur, and then to redesign the processes so that the new model eliminates the possibility of failure. There are many ways to evaluate the safety and quality of healthcare services, but when trying to design a safe care environment, a proactive approach is far preferable to a reactive approach.
8. **The significance of Project outcomes:** This project **e**nhanced staff (knowledge, attitude, and practice) to prevent from sentinel events. The sensitive areas were identified for infant induction was delivery room, nursery, and obstetrics and gynecology ward and Private room. Therefore, these clinical areas were the focus of strategies to promote infant safety to promote consistency in knowledge, attitude, and practice. In 2016, a
9. variety of strategies were implemented including a review of policies, optimum staffing, training of staff, vigilant practices of staff and electronic access at sensitive areas.
10. **Post project sustainability of desired outcomes**: Success in implementing essential structural and process components of the infant safety program have resulted in improvement from April 2016. The program continues to evolve compliances of policies via monthly audit and Mock drill for staff which can save the cost prevent from lawsuits and bad market image of the organization.