

Using Failure Mode, Effect and Criticality Analysis to improve safety in the cancer treatment prescription and administration process.

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[Failure Mode, Effect and Criticality Analysis](#) (FMECA) is a prospective method for identifying and preventing potential [error risks](#). Using FMECA, public health medical residents calculated a Risk Priority Number (RPN), or criticality, for each possible failure mode in cancer treatment prescription and administration. Each phase of the cancer treatment [process](#) had at least one critical step identified, and actions were developed to reduce the likelihood of the error occurring and/or to increase the likelihood of the error being detected.