Southern Health Santé Sud

A3 Report

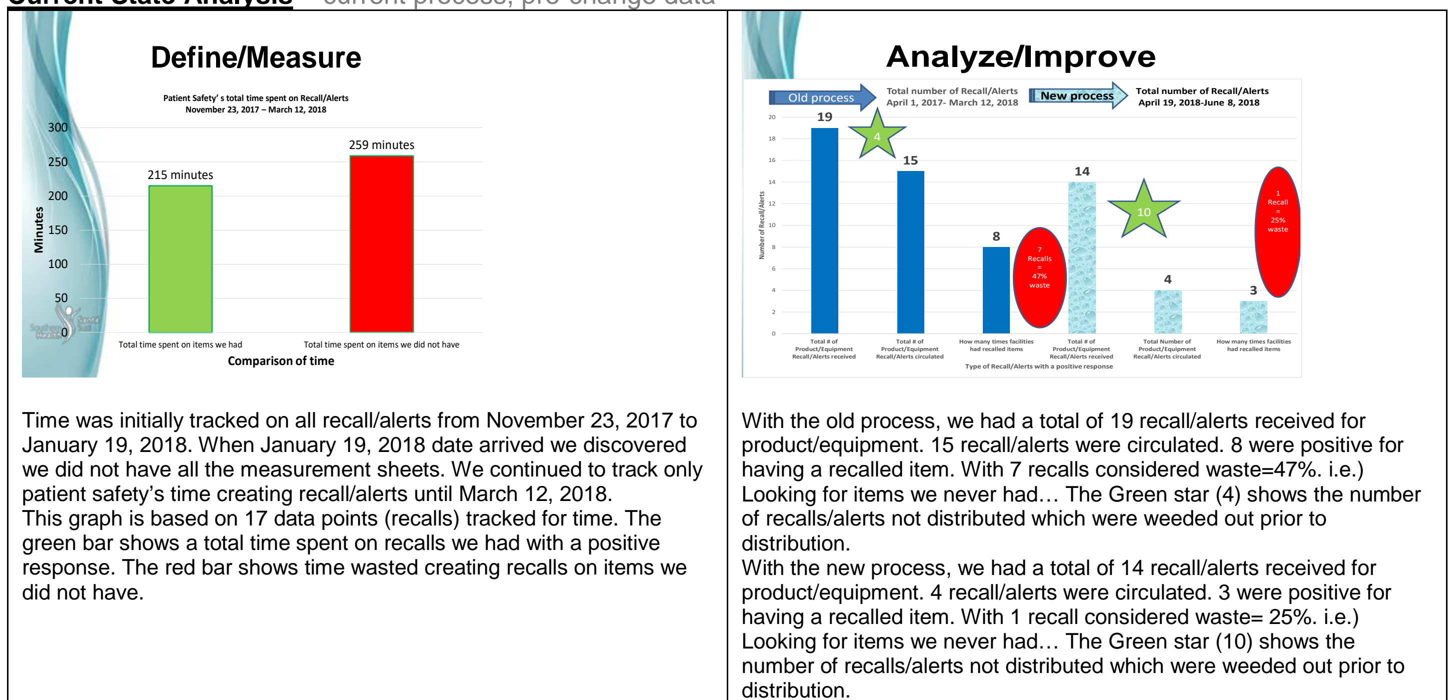
Project Details

Organization/SDO	Southern Health – Santé Sud	Site/Program	Bethesda Regional Health Centre
Project Description (7 words max)	Total Recall	**Project Facilitator/Belt Level**	Cathy Asham/Jo-Anne Thompson- Yellow belt
Project Sponsor	Heidi Wiebe	**Project Team Members**	Brenda Ross, Tim Siran, Elizabeth Doyle, Crystal Gurney, Mike Wlock, Cailin Gagnon
Project Start Date	November 16, 2017	**Project End Date**	31 August 2018

Problem Statement

The regional recall/alert process involves too many steps/people because of inappropriate distribution, lack of role clarity and limited control of non-stock items. This leads to staff frustration/feeling overwhelmed with competing priorities and an increased workload.

Current State Analysis – current process, pre-change data



Time was initially tracked on all recall/alerts from November 23, 2017 to January 19, 2018. When January 19, 2018 date arrived we discovered we did not have all the measurement sheets. We continued to track only patient safety's time creating recall/alerts until March 12, 2018.
This graph is based on 17 data points (recalls) tracked for time. The green bar shows a total time spent on recalls we had with a positive response. The red bar shows time wasted creating recalls on items we did not have.

With the old process, we had a total of 19 recall/alerts received for product/equipment. 15 recall/alerts were circulated. 8 were positive for having a recalled item. With 7 recalls considered waste=47%. i.e.) Looking for items we never had… The Green star (4) shows the number of recalls/alerts not distributed which were weeded out prior to distribution.
With the new process, we had a total of 14 recall/alerts received for product/equipment. 4 recall/alerts were circulated. 3 were positive for having a recalled item. With 1 recall considered waste= 25%. i.e.) Looking for items we never had… The Green star (10) shows the number of recalls/alerts not distributed which were weeded out prior to distribution.

Project Aim – what you plan on achieving and by when

By the end of May 2018, 100% of Recall/Alerts for product/equipment will only go to affected sites.

Implementation Plan

	PDSA – Brief Description	Implementation Date
1	Before a Recall/Alert is distributed, connect/consult with maintenance/logistics	April 15, 2018
2	Identify Recall/Alert priority level in the email subject line i.e. HIGH, MEDIUM, LOW	Immediately
3	Education will be offered on how to complete the Recall/Alert forms	April 30, 2018

Project Outcomes – improvements achieved, post-change data, saving summary, potential for spread and/or continued PDSA work

Post-change Data:

Improve	Improve
Time spent on creating/looking for recall/alerts • **PRE-IMPROVEMENT** – Patient Safety time spent creating one recall/alert=~27 minutes – 27 minutes x 15 recall/alert= 405 minutes = 6.75h – Time spent looking for **one** recall/alert per CSM=~20 minutes – 4 CSM x 20 minutes=80 minutes in total at Bethesda Hospital – 80 minutes x 15 recalls/alerts= 1200minutes = 20h – 60 hours combined from the three Regional Facilities • **POST-IMPROVEMENT** – Patient Safety time spent creating one recall/alert=~27 minutes – 27 minutes x 4 recall/alert=108 minutes = 1.8h – Time spent **on one** recall/alert per CSM=~20 minutes – 4 CSM x 20 minutes=80 minutes in total at Bethesda Hospital – 80 minutes x 4 recalls/alerts= 320 minutes = 5.3h – 15.9 hours combined from the three Regional Facilities	19.65 hours saved…

We have a 75% confidence level that we have improved the process for product recalls

Improvements/Changes Noted:

Savings Summary *(report as applicable)*	
Indicator	
Cost Savings	• Since time saved is being diverted to other work in the employee's respective portfolio, there are no hard savings
Patient Safety	• Time saved was time released back to care for front line staff looking for product we did not have. • CSM's and CRN's have more time to manage their units. Less time spent on administrative tasks such as looking for products we don't have. • Executive Assistant/Administrative Assistant have more time for other competing priorities as calling for product recall/alerts stops workflow • Distribution Centre's have more time to focus on inventory management, i.e. product distribution • Patient Safety coordinators have more time to focus on other competing priorities as processing product recall/alerts stops workflow
Cycle Time	• 19.65 hours saved • PS saved 4.95 hours not completing for product recall/alert we did not have • CSM's and CRN's were saved 14.7 hours looking for product recall/alert we did not have • Think about all the additional time saved (noted in the next three bullets below) • Two Distribution Centre's were saved on average 30 minutes each not looking for the product recall/alerts we do not have, as only one out of three distribution center's is looking for the product • On average an Executive Assistants were saved 30 minutes (per product recall/alert) fanning out, tracking and following up on product recall/alerts we did not have • On average an Administrative Assistants were saved 30 minutes (per product recall/alert) fanning out, copying, tracking, and following up on the product recall/alert we did not have
Client Flow	
Other	

Controls Utilized – type of change and description put into place to sustain PDSA improvement

1. A fundamental change was created to streamline the contacting of only one Distribution Centre for a response on behalf of the Region (for product).
2. Standard work has been created at the beginning of the process to contact only one Distribution Centre for a response on behalf of the Region for product. The future state map included in the presentation will be the process moving forward. This will be incorporated into the Recall/Alert Policy Checklist
3. Standard work was created by using an Email Nomenclature indicating HIGH PRIORITY, MEDIUM PRIORITY, LOW PRIORITY – Recall, Alert, or Alert with Action – then what is the recall/alert will be sent out for all Product Recall/Alerts
4. The current policy/procedure for Recall/Alerts will be revised to incorporate the new changes

Spread Plan – how will you spread the improvements to other areas/programs?

This now the current process for product recall/alerts.