

Quality Improvement Project  
Report Out  
for  
**TOTAL RECALL**  
July 26, 2018



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off your life.

# TOTAL RECALL



***Production Crew: Cathy Asham, Elizabeth Doyle, Cailin Gagnon, Mary Heard, Brenda Ross, Tim Siran, Jo-Anne Thompson, Heidi Wiebe, Mike Wlock***

# Define

**This LEAN project is looking for improvement opportunities to streamline the recall/alert process to ensure only those that need to act on a recall/alert are being requested to do so.**

**Bethesda Regional Health Centre was originally chosen to measure the current process, as well as test potential improvements. Additional retrospective data supplemented the current process.**

# 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.**



Blue-decision point

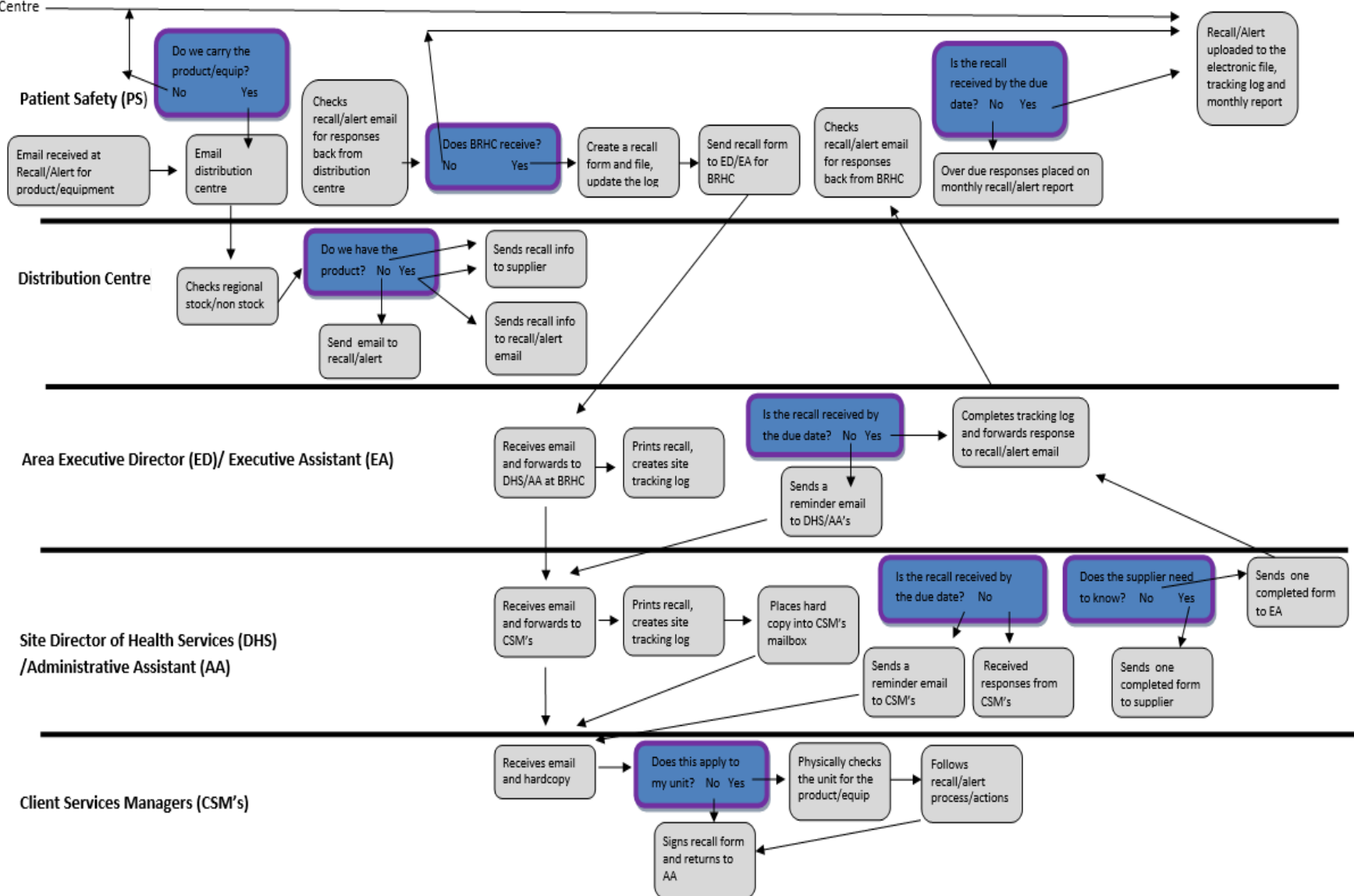
Grey-process

BRHC-Bethesda Regional

Health Centre

## Process Map – Total

### Recall



# Initial proposed measures

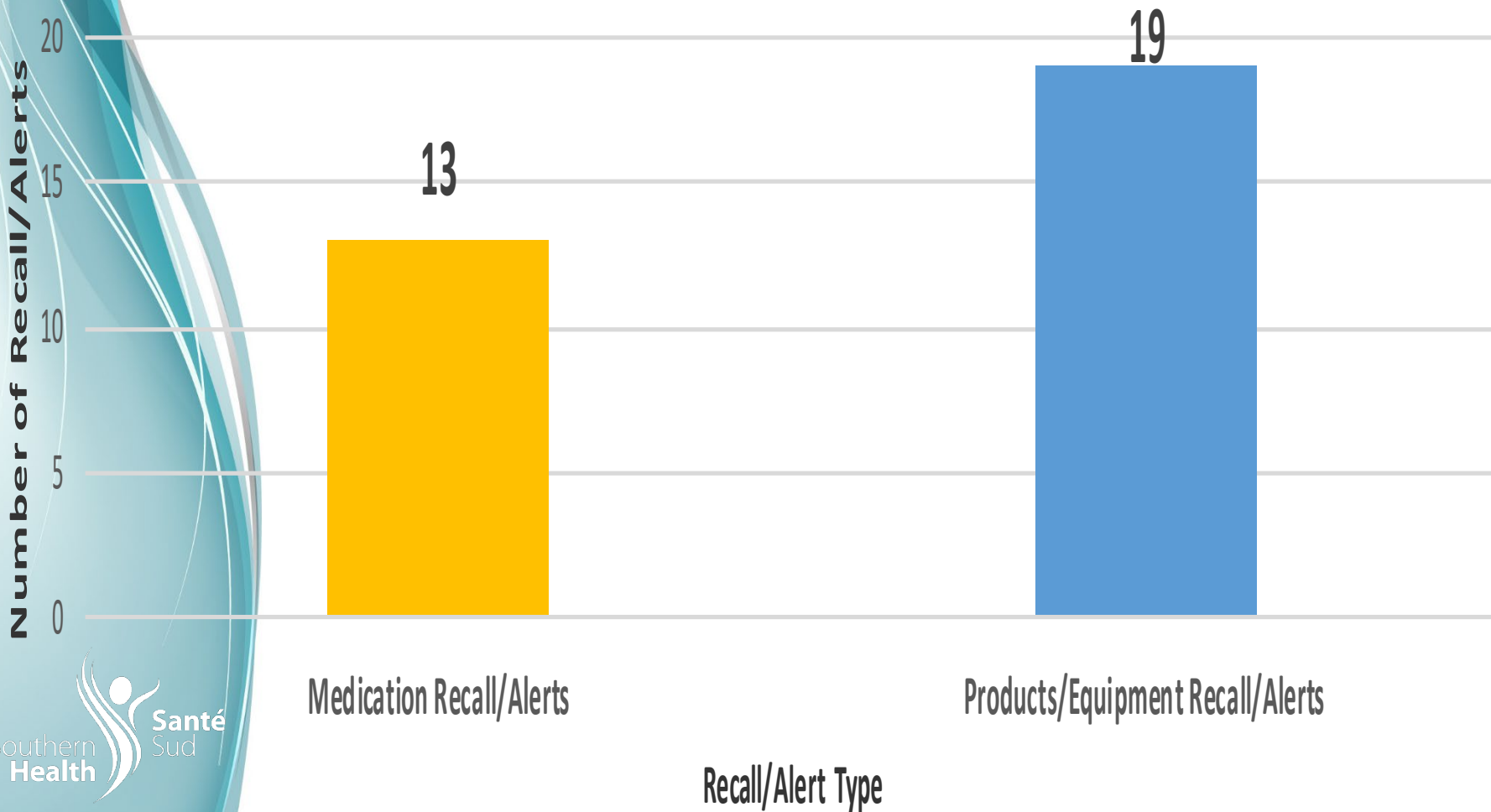
1. *Time it takes to create a regional recall from start to fan out including i.e. create form, file, upload, track, add to monthly report and send out.*
2. *How often product/equipment is carried and which units/departments carry the product/equipment*
3. *How many days from when the recall/alert is received at the site from executive assistant (EA) to when the recall is completed and forwarded back to the EA.*
4. *Number of times the recall/alert is not applicable to the site*
5. *Number of times reminders are send to CSM's to complete form*
6. *Time it takes to complete a recall/alert on the unit by CSM*

# Additional Measures

- *Time it takes to create a regional recall from start to fan out including i.e. create form, file, upload, track, add to monthly report and send out.*
- *Review retroactive data points for Medication recalls/alerts distributed in comparison to Product/Equipment*

# Define/Measure

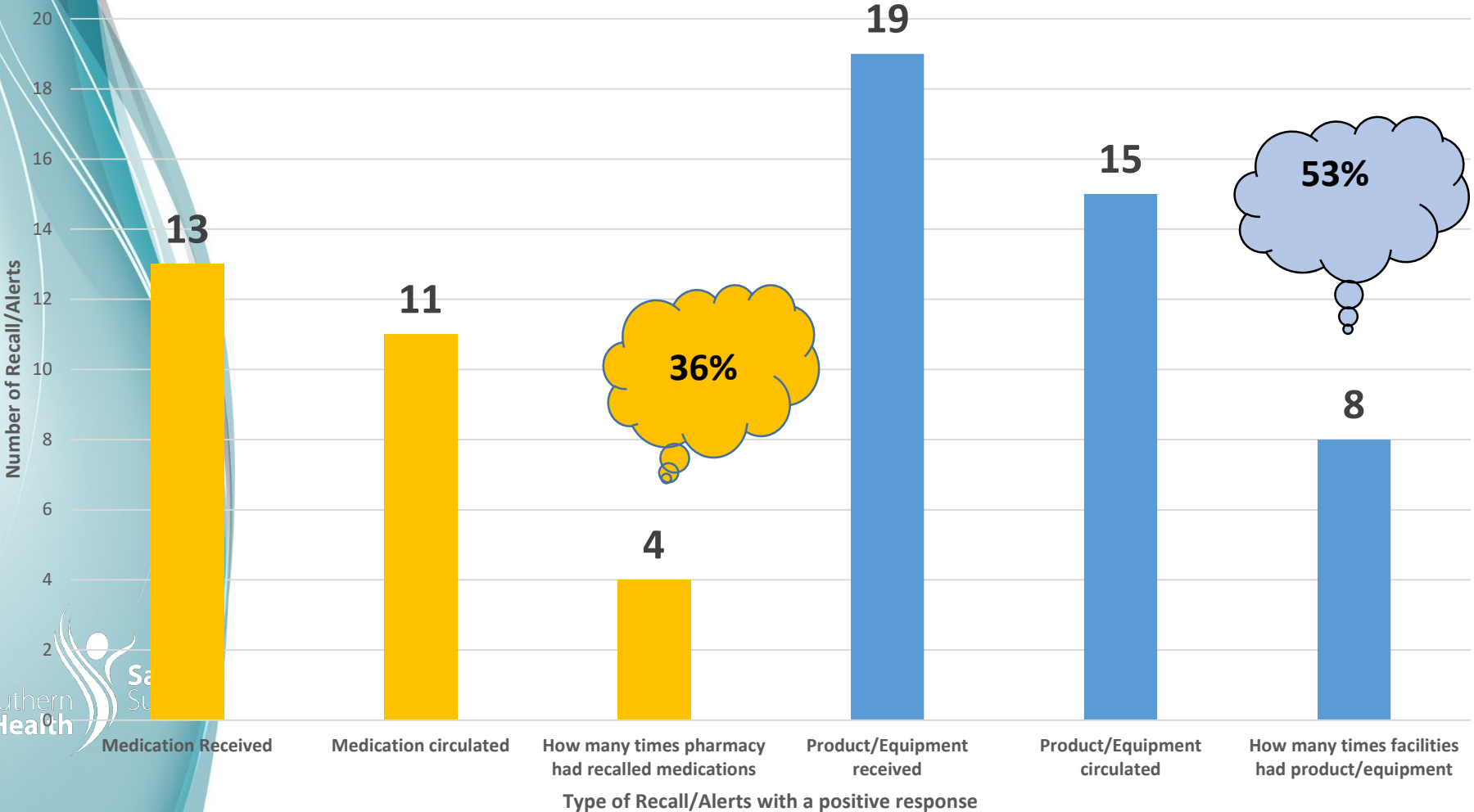
Total number of Recall/Alerts Retrospectively Reviewed  
April 1, 2017-March 12, 2018





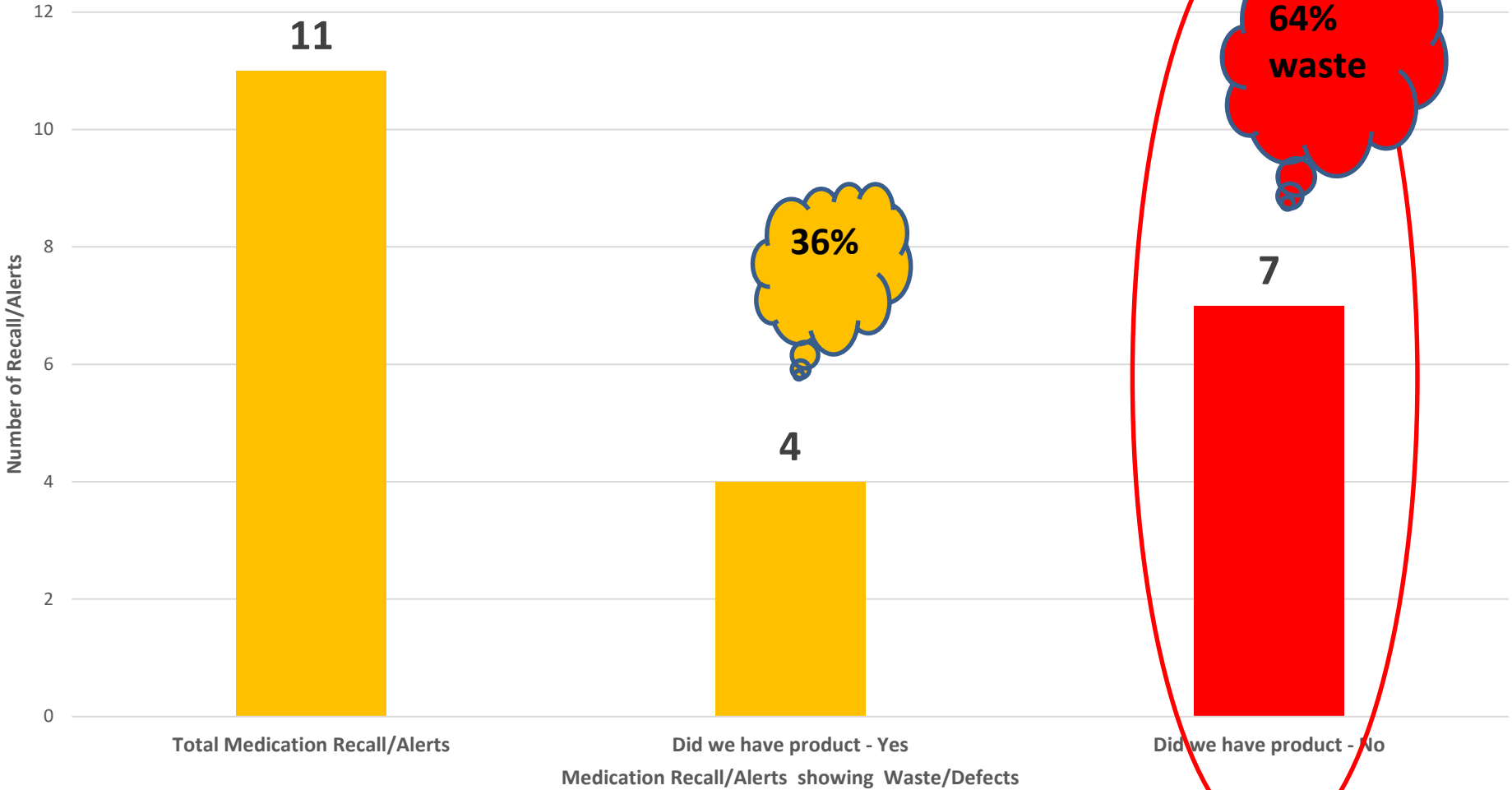
# Define/Measure

Total number of Recall/Alerts  
April 1, 2017- March 12, 2018



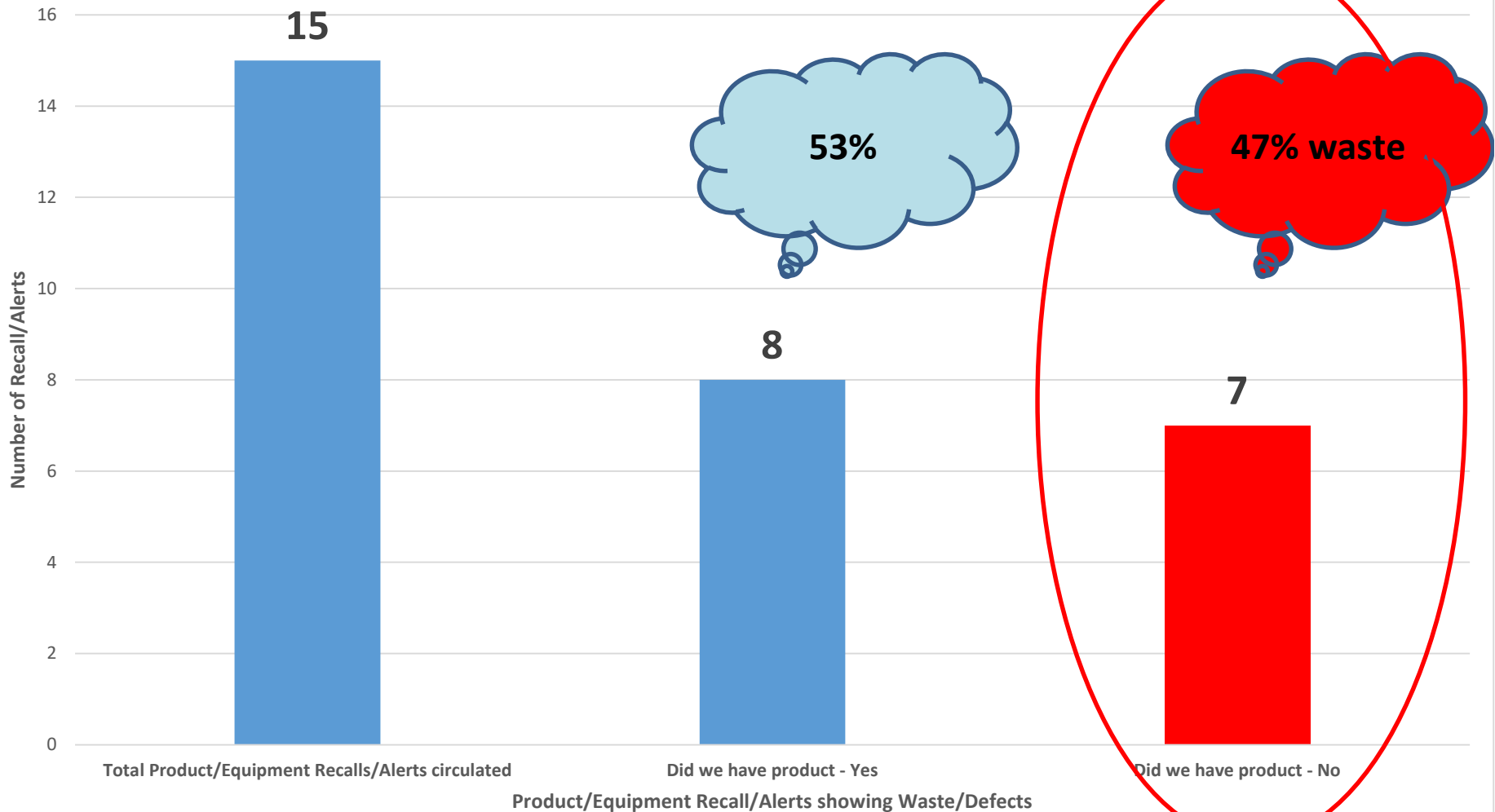
# Define/Measure

Total number of Recall/Alerts Retrospectively  
Reviewed for circulated Medications  
April 1, 2017-March 12, 2018



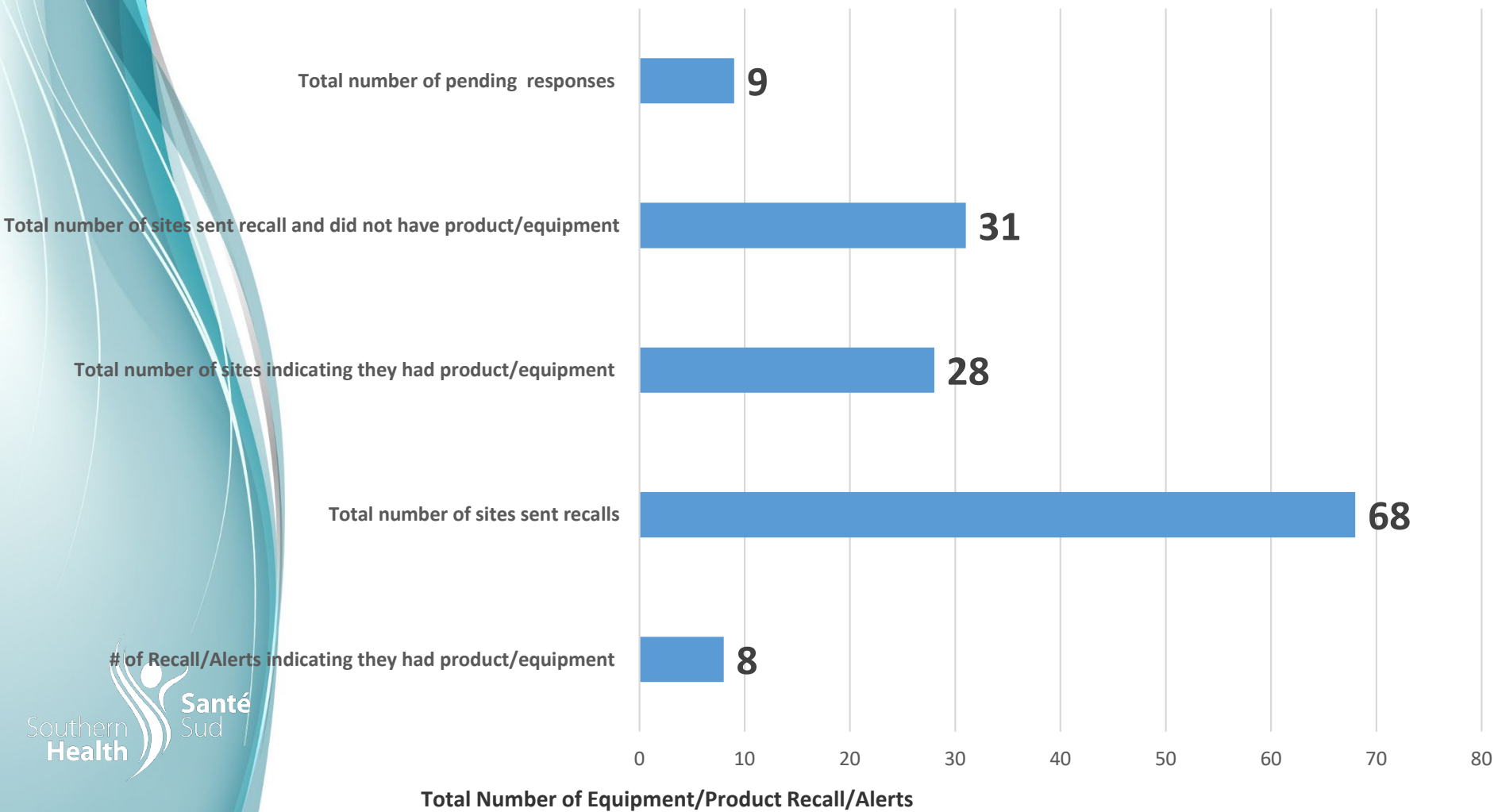
# Define/Measure

Total number of Recall/Alerts Retrospectively Reviewed for  
Product/Equipment  
April 1, 2017-March 12, 2018



# Define/Measure

Recalls/Alerts for Product/Equipment  
further analyzed  
April 1, 2017-March 12, 2018



# Define/Measure

List of 8 positive responses for Product/Equipment

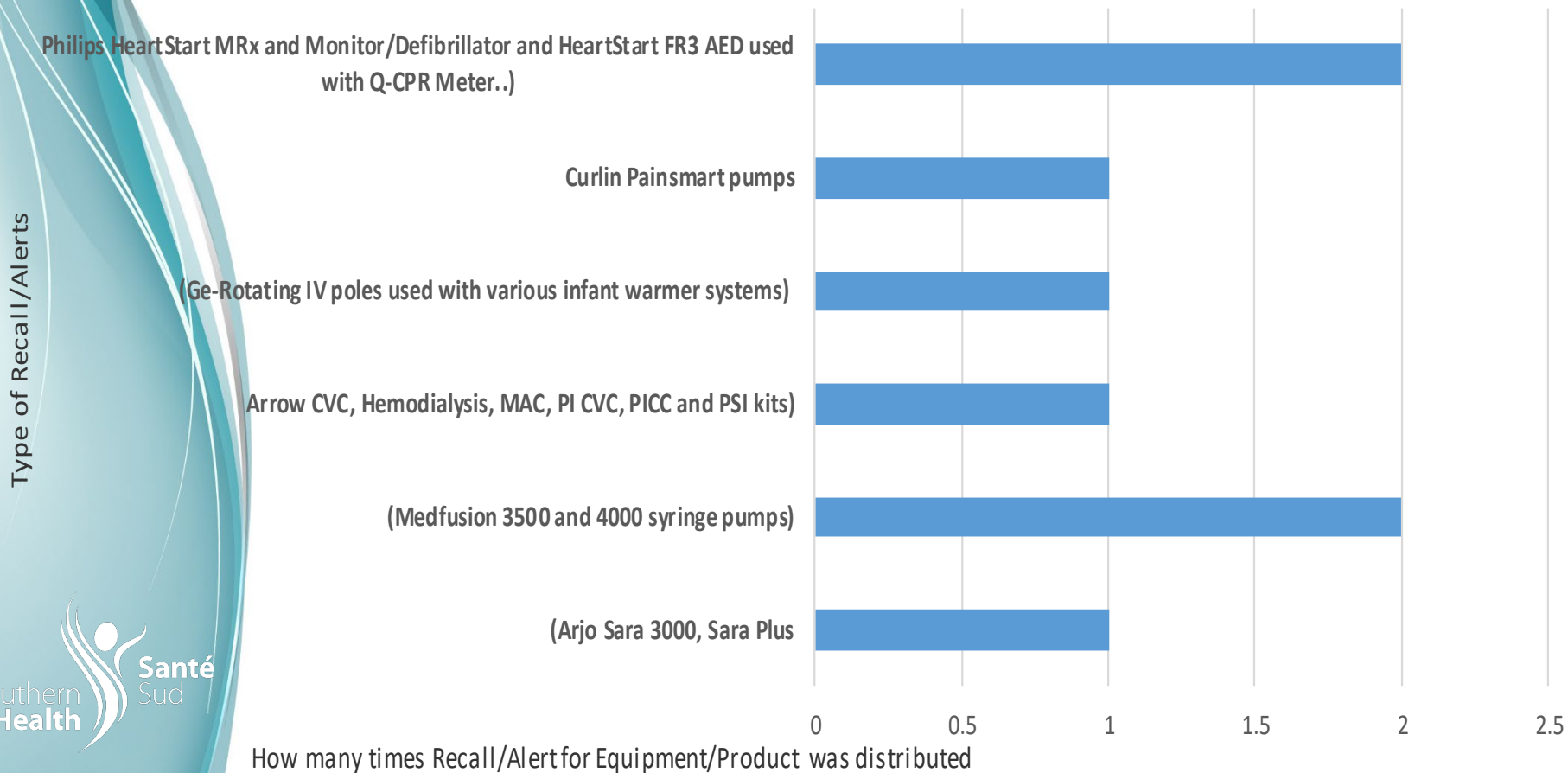
April 1, 2017-March 12, 2018

1. Arjo Sara 3000, Sara Plus
2. Medfusion 3500 and 4000 syringe pumps
3. Arrow CVC, Hemodialysis, MAC, PI CVC, PICC and PSI Kits
4. Ge-Rotating IV poles used with various infant warmer systems
5. Curlin Painsmart pumps
6. Philips HeartStart MRx and Monitor/Defibrillator and HeartStart FR3 AED used with Q-CPR Meter
7. HeartStart FRx HeartStart Home and HeartStart Onsite AED's
8. Medfusion 3500 and 4000 syringe pumps

# Define/Measure

April 1, 2017-March 12, 2018

## Type of Recall/Alert for Product/Equipment

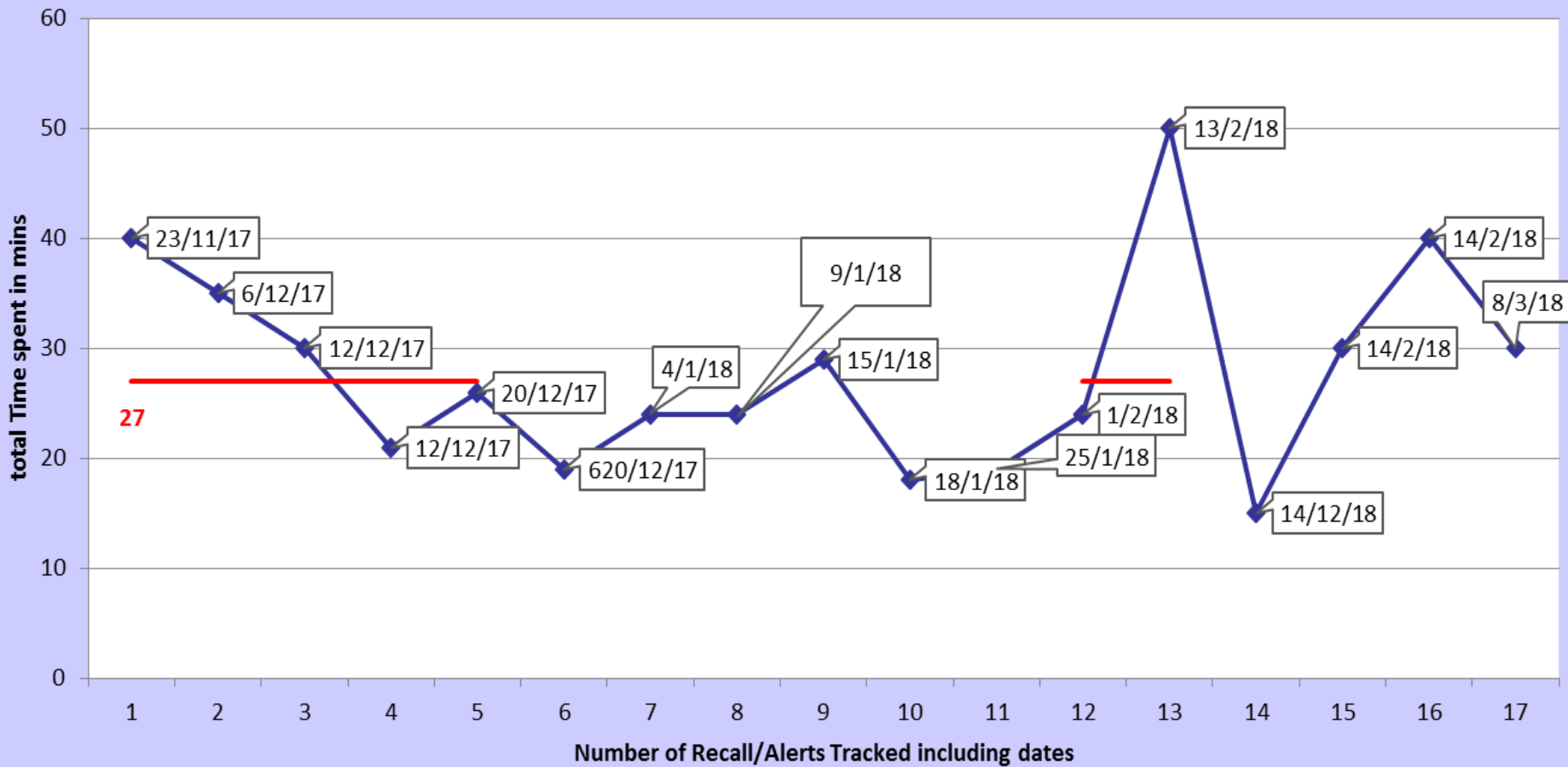


Type of Recall/Alerts

# Define/Measure

Average time to create a Recall/Alert  
April 1, 2017- March 12, 2018

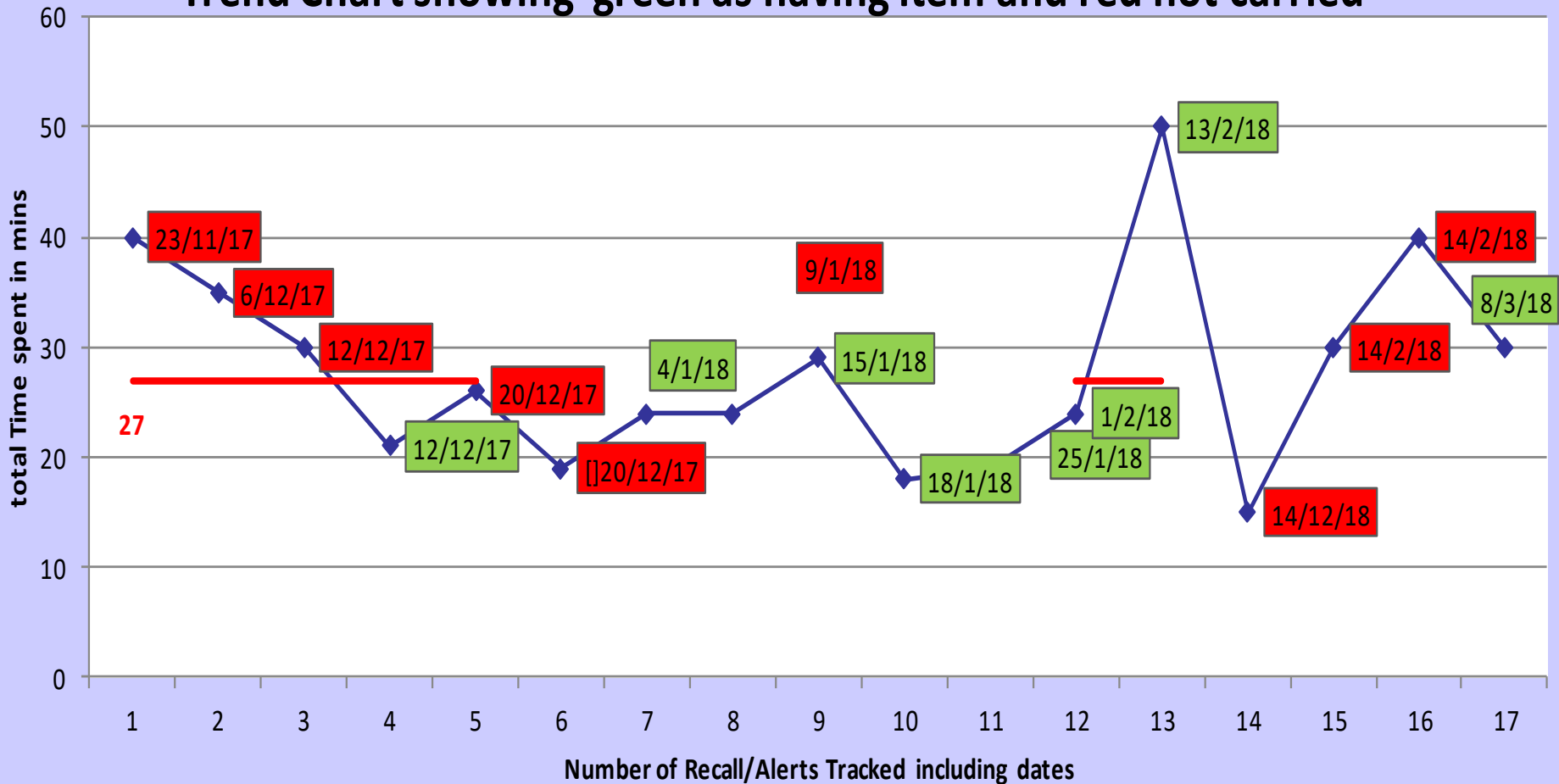
## Trend Chart with median line



# Define/Measure

Average time to create a Recall/Alert  
April 1, 2017-March 12, 2018

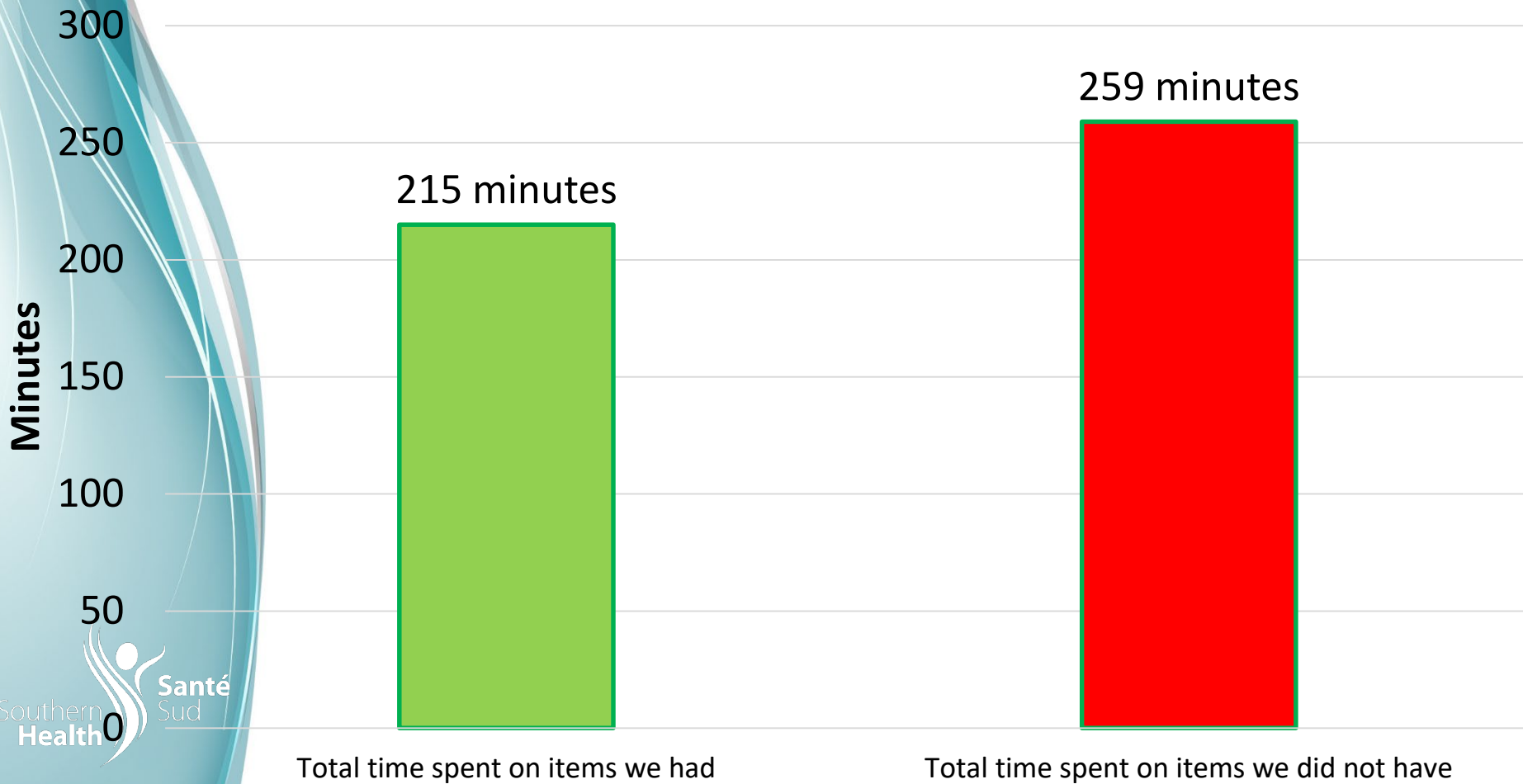
Trend Chart showing green as having item and red not carried





# Define/Measure

Total time spent on Recall/Alerts

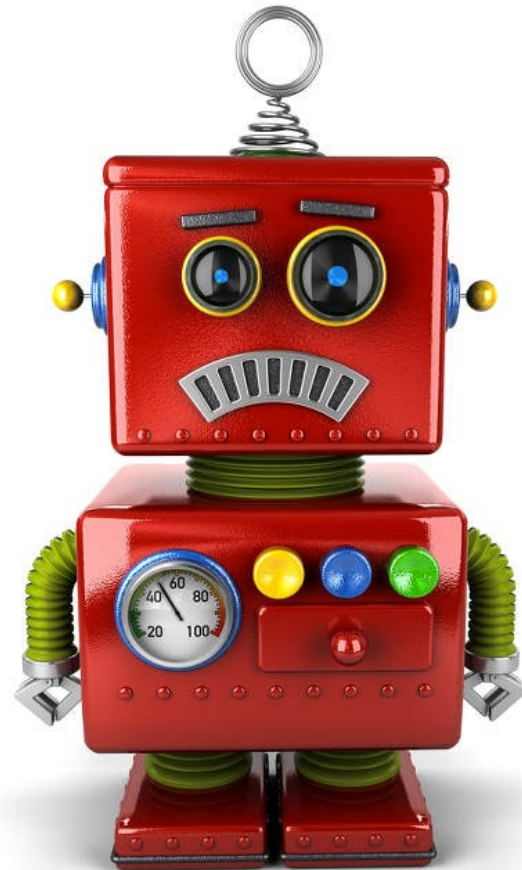


Total time spent on items we had

Total time spent on items we did not have

Comparison of time

# Standard Work



## Standard work Q & A:

**Who does the work**

**What is done**

**When should it be done**

**How the task should be done**

**What to do if there is a problem**

# Analyze/Improve

- *Aim statement:*

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

# Analyze/Improve

## ***PDSA 1***

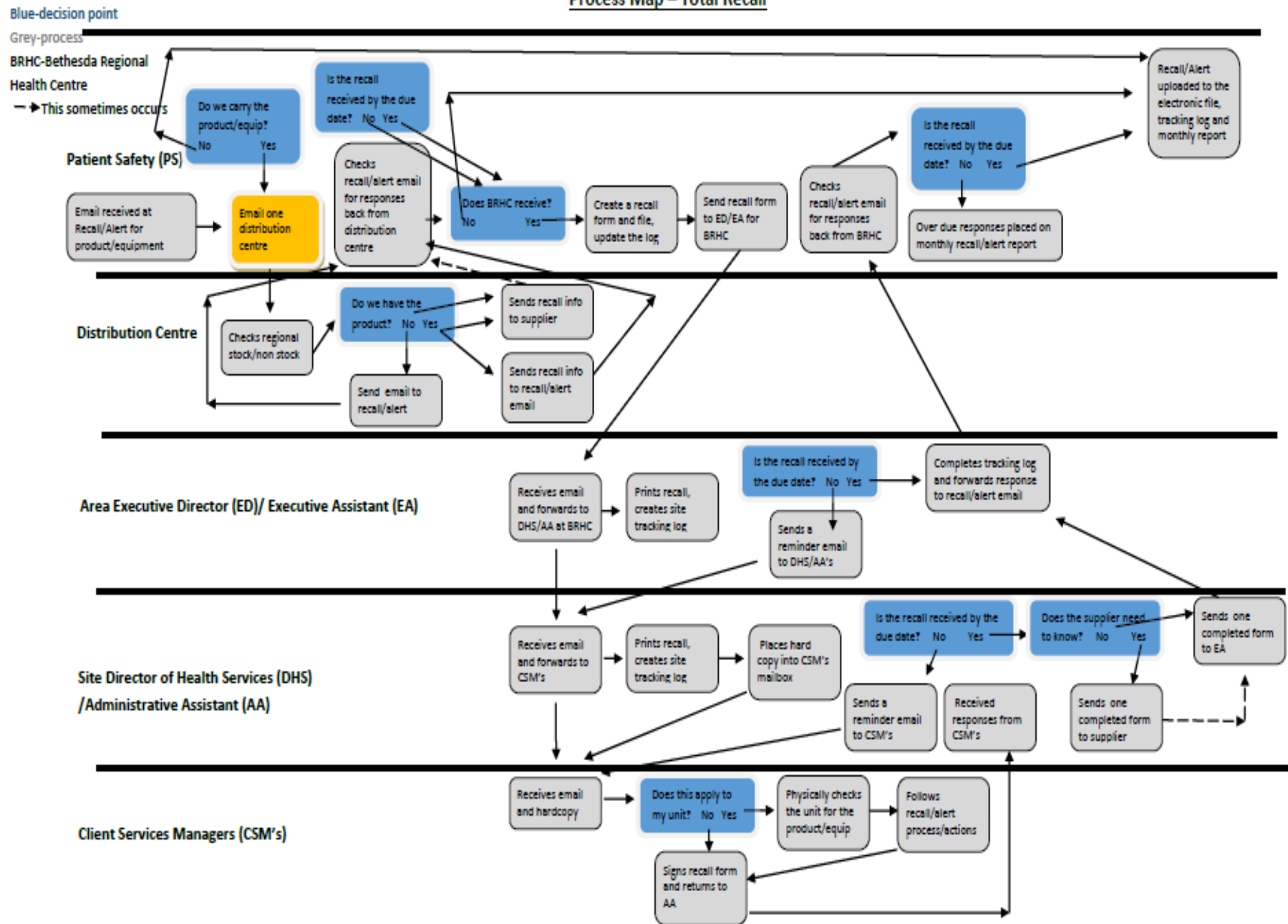
### *Description:*

*Before a recall/alert is distributed, connect/consult with maintenance/logistics*

### *Date Implemented:*

*April 15, 2018*

## Process Map – Total Recall



# Analyze/Improve

## ***PDSA 2***

### *Description:*

*Identify Recall/Alert priority level in the email subject line i.e. HIGH, MEDIUM, LOW*

### *Date Implemented:*

*March 28, 2018*

# Analyze/Improve

- *Staff comments and customer feedback on the improvements for the new nomenclature for the email subject line i.e. “HIGH PRIORITY, MEDIUM PRIORITY, LOW PRIORITY- Recall or Alert- Information pertaining to the subject”*
- Looks great!
- Great job!



# Analyze/Improve

## ***PDSA 3***

*Description:*

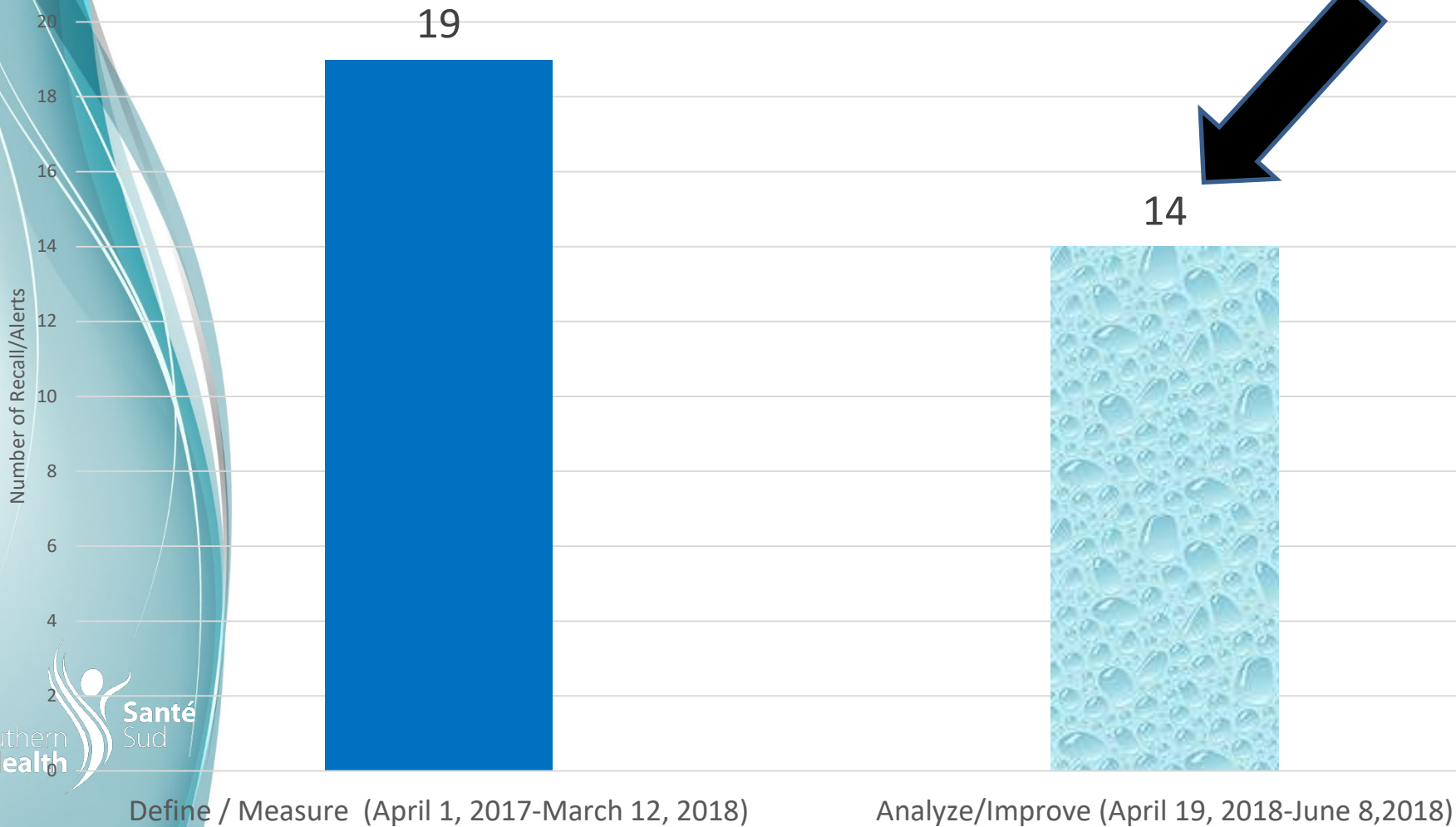
*Education will be offered on how to complete the  
Recall/Alert forms*

*Date Implemented:*

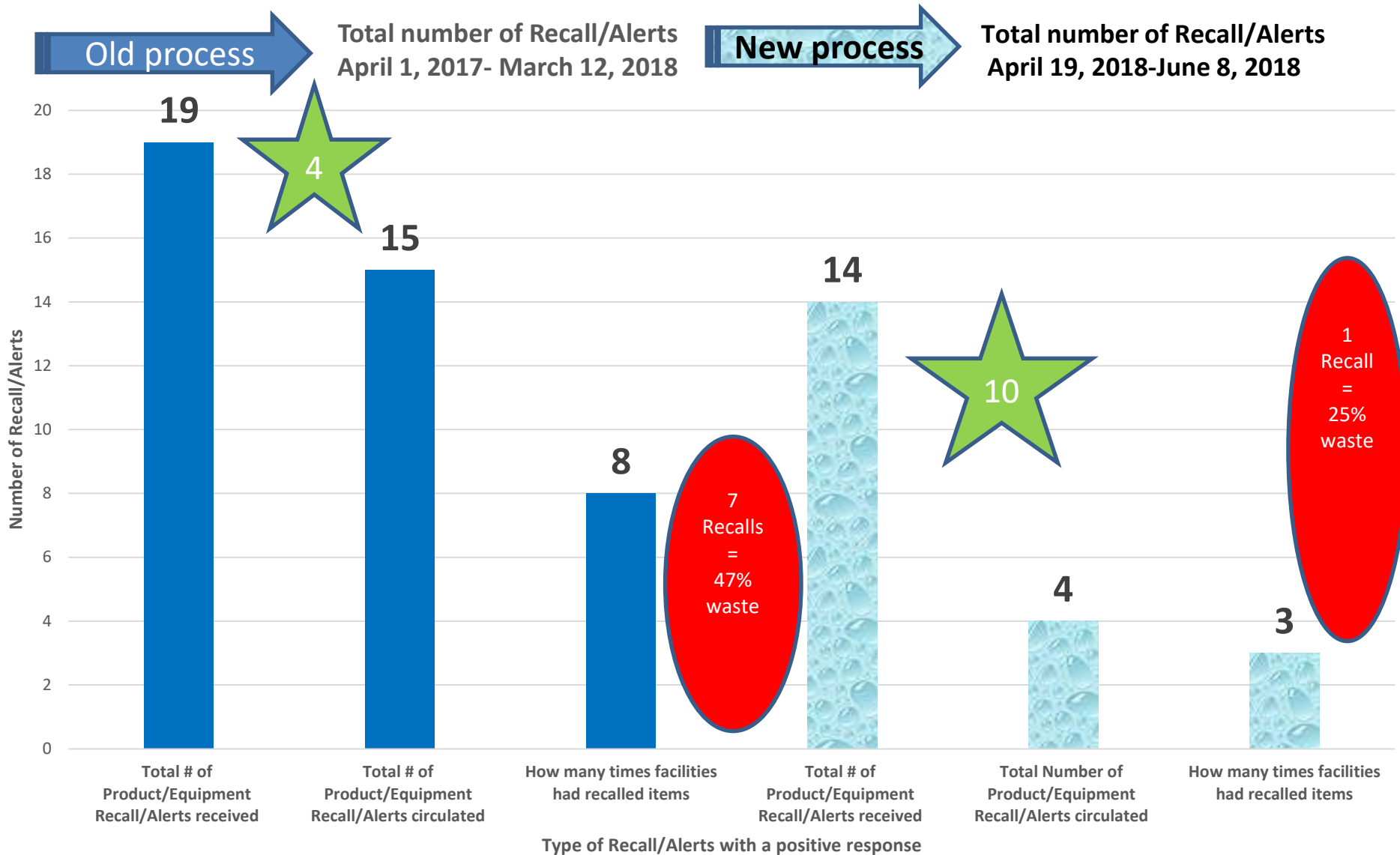
*April 30, 2018*

# Analyze/Improve

Number of Recall/Alerts for Product/Equipment



# Analyze/Improve



# Improve

19.65 hours saved...

# Improve

- *Aim statement (this is a duplicate slide to remind the audience what the aim is)*

*By the end of the course, we will have a 75% improvement in product/equipment recall for all sites however we had a 75% improvement in product/equipment recall that we have improved the product/equipment recall.*

75%

# Control

- One designate from a Distribution Centre (BRHC) will respond on inquiries regarding product recalls/alerts for the region. This has improved duplication/redundancy and cost savings of time wasted to identify if we carry a product.
- Nomenclature- *“HIGH PRIORITY, MEDIUM PRIORITY, LOW PRIORITY”*- at the beginning of all Recall/Alerts, then what type of *“Recall, Alert or Alert with Action”* then what the recall/alert is about will be sent out regionally
- *The current Recall/Alert Policy will be revised to incorporate the changes, with two training sessions following*

# Lessons Learned

- The medication recall alert process was initially assumed as a process to follow.
- Product is standardized through the three Regional Distribution Centers
- One designate from a Distribution Centre (BRHC) will respond on inquiries regarding **product** recalls/alerts which has improved duplication/redundancy and cost savings of time wasted to identify if we carry a product.
- The HIPPO program for an Equipment database has limitations. *Therefore recalls/alerts involving equipment will remain as previous to the LEAN project.*
- Contract sites – are their own entities. Southern Health – Santé Sud works in partnership with the contract sites. Equipment and products can be ordered through the region or the contract sites can order on their own.

# Next Steps

- Revise the Recall/Alert Policy
- Offer two education sessions on the Recall/Alert process
- Acknowledge in the out of office email reminder as to who is the contact regarding vacation coverage for the Distribution Centers. As an FYI, cc the other two distributions center's incase this has not been completed as well as the regional manager logistics and supply chain
- A potential for the Region to evaluate Hippo expansion or an Equipment database
- Executive Assistant to discuss at a Area Leadership Team meeting regarding the current process for equipment recall/alerts. Does the contract site receive recall/alerts directly from the vendor? Is this a duplicate process(i.e. we send to them too for the same equipment)?
- It is unknown if Shared Health will change the recall/alert process



# The Team!

Team Members:

Heidi Wiebe (Sponsor)

Mary Heard (Mentor)

Elizabeth Doyle (Administrative Assistant)

Tim Siran (Manager-Purchasing and Supplies)

Brenda Ross (Executive Assistant)

Mike Wlock (Manager-Purchasing and Supplies)

Jo-Anne Thompson and Cathy Asham

(Patient Safety, Yellow Belt Candidates)

