Huddling Together:
A Relentless Focus on Medication Safety

Lori Paine, DrPH, MS, RN
Casey Wilbert, PharmD, MBA
Rochester Regional Health, Rochester, New York

Who We Are

- Rochester Regional Health (RRH) is an integrated healthcare system spanning Western and Upstate New York
- 9 Acute Care Hospitals, 400+ Clinics, Long Term Care, Home Care, Hospice and ACM Labs

The Problem

Medication errors across large integrated health systems require a relentless commitment to learning and mitigating risks across the continuum of care. At RRH, there was not a forum where all medication safety stakeholders could discuss errors, issues, concerns or innovations.

While various facilities and service lines may encounter different errors, it is imperative to create opportunities for situational awareness and collaboration to solve complex medication issues and facilitate organizational learning.

Actions Taken

On September 15, 2023, RRH launched a weekly system-wide Medication Safety Huddle to detect and respond to medication risks. Since then, 40+ Pharmacists, nurses, providers, informaticists, regulatory, quality and safety staff from across our geographically diverse health system actively participate every week.

The goal in convening this multidisciplinary group was to:

- Facilitate situational awareness
- Promote system improvements in the medication use process
- Eliminate preventable harm

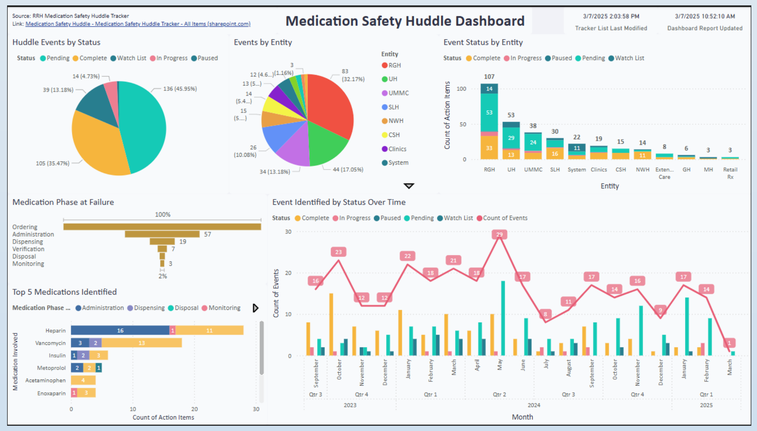
This weekly forum features:

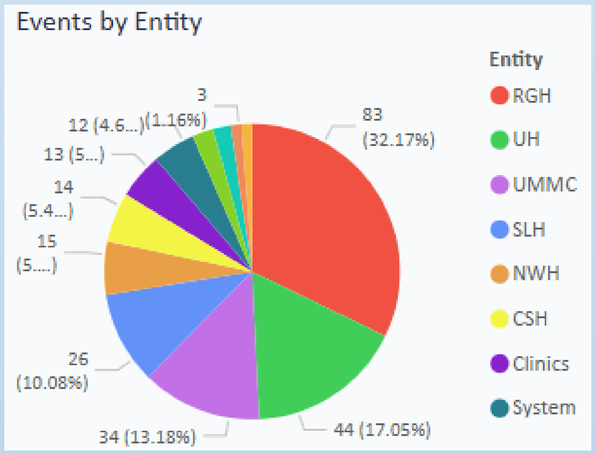
- A "round robin" format allowing each facility to report on recent events and risks
- Sharing relevant ISMP Alerts
- Recognizing stellar efforts to improve medication safety and good catches
- Collaborating, improving and communicating system-wide

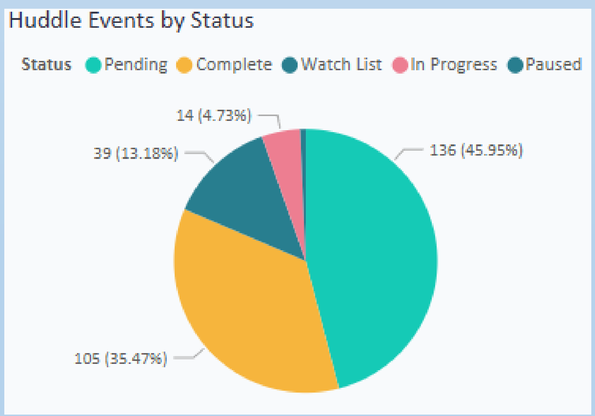
Results

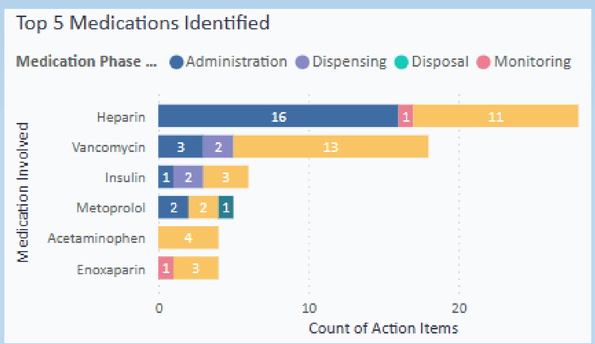
Since inception:

- >300 events reviewed across all care settings
- 33 system-wide solutions implemented
- Subgroup for anti-coagulation formed









Lessons Learned

1. ***Action focused meetings keep attendance up*** – many times, meetings can become circular discussions that result in more meetings being scheduled with little actionable output. Our Medication Safety Huddle has output every week with assigned tasks. Routine report-out of follow-up is expected and required to move events from "in progress" to "complete"

2. ***Diversity of thought drives innovative solutions*** – by having representation from around the system, ideas are generated not only from the facilities/disciplines where errors are reported, but from colleagues who may have a different perspective or ideas based on their specialty or practice area

3. ***Tracking and data capture are crucial for success*** – the metrics of this effort continue to evolve and accumulate. Disciplined tracking and trending has proven to guide priority setting and keep the group goal-focused

4. ***Good news travels fast*** – by getting the word out to all levels of leadership across the organization, the Medication Safety Huddle has gained recognition from local facility level leaders, system Executives as well as Board Committees. This effort has been an exemplar of our core value -- the relentless focus on quality and safety.

Contact

Lori Paine, DrPH, MS, RN
VP, Patient Safety Officer
Rochester Regional Health

Casey Wilbert, PharmD, MBA
VP, Chief Pharmacy Officer
Rochester Regional Health

*All data as of 5/3/2024

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