



**Empowering Front-Line Nurses: A Structured Intervention Enables Nurses to Improve Medication Accuracy**

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## Work Mission and Goals

Mission: Transform the hospital work environment by developing clinicians' leadership skills in order to create and lead sustainable systems change.

Outcome Goal: To improve medication error rates by 50% from baseline in 8 bay area hospitals within 18 months.

Outcome Goal: To improve sepsis-related mortality rates by 25%

Stealth Goal: Improve leadership abilities in front line clinicians by 50% within 18 months

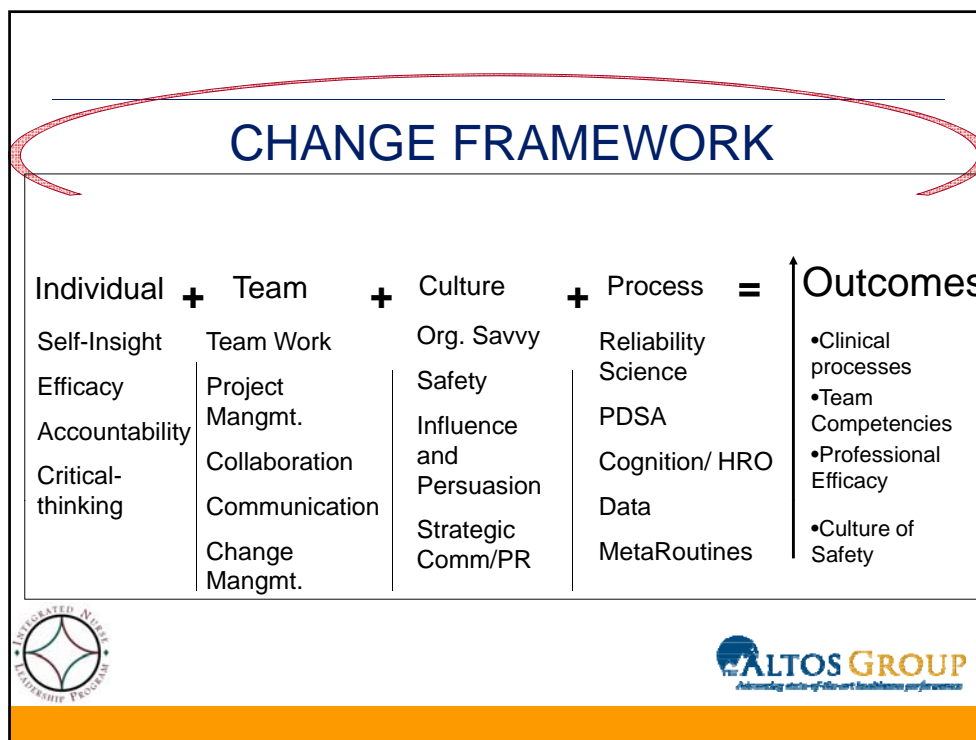
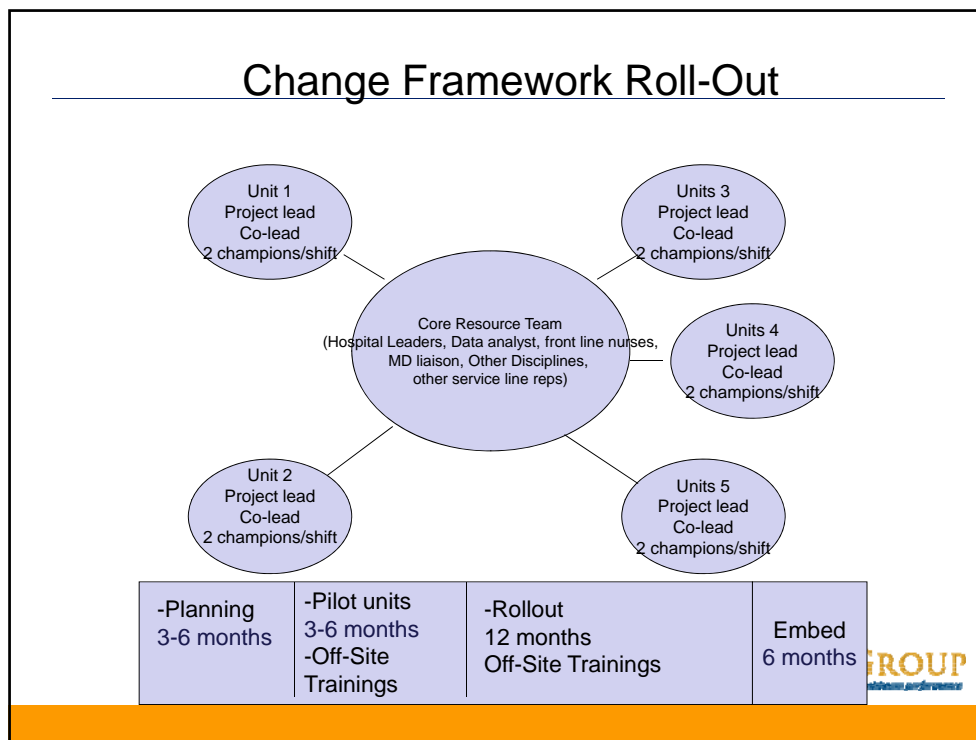


## 18 month Program Structure

- 7-10 member Core Resource Team; 4-6 member Unit Teams
- 4-6 member Executive Team
- 6-8 Off-site training sessions
  - Workshop-based, hands-on knowledge exchange
- Intersession assignments
  - message maps, run charts, stakeholder analysis, process mapping, data collection, meetings
- Regular data collection and small tests of change at the local level
- Funding provided by:

GORDON AND BETTY  
**MOORE**  
FOUNDATION *Creating positive outcomes for future generations*







## Scope/Size/Cost of Medical Errors\*

- Medical errors are the eighth leading cause of death in the US.
- One landmark studies on medical errors indicated 70% were preventable;
- The IOM report estimates that medical errors cost the Nation approximately \$37.6 billion each year;
- IOM reports that ALL medication errors, on average (2007) costs \$10,600.00

\*Source: AHRQ, IOM



## Total Study Method: Observation and Error Review



- **Naïve observation** methodology is a process whereby the observers do not know the actual medication order but observe the entire preparation and administration process.

**Comparative record review** is performed after observation is completed to determine the number, type of errors and frequency of each type of medication error.

\*Source: Flynn, E., et al.: *Am J Health Syst Pharm.* 59:436-46, 2002.



## PROCESSES\*

(All 6 = Sum of Safety Processes)

- Compared medication with MAR
- Medication labeled from prep to admin
- Checked two forms of ID
- Explained medication to patient, where appropriate
- Charted medication immediately after administration
- Distracted or interrupted during preparation/ administration

\*Source: Collaborative Alliance for Nursing Outcomes, CALNOC

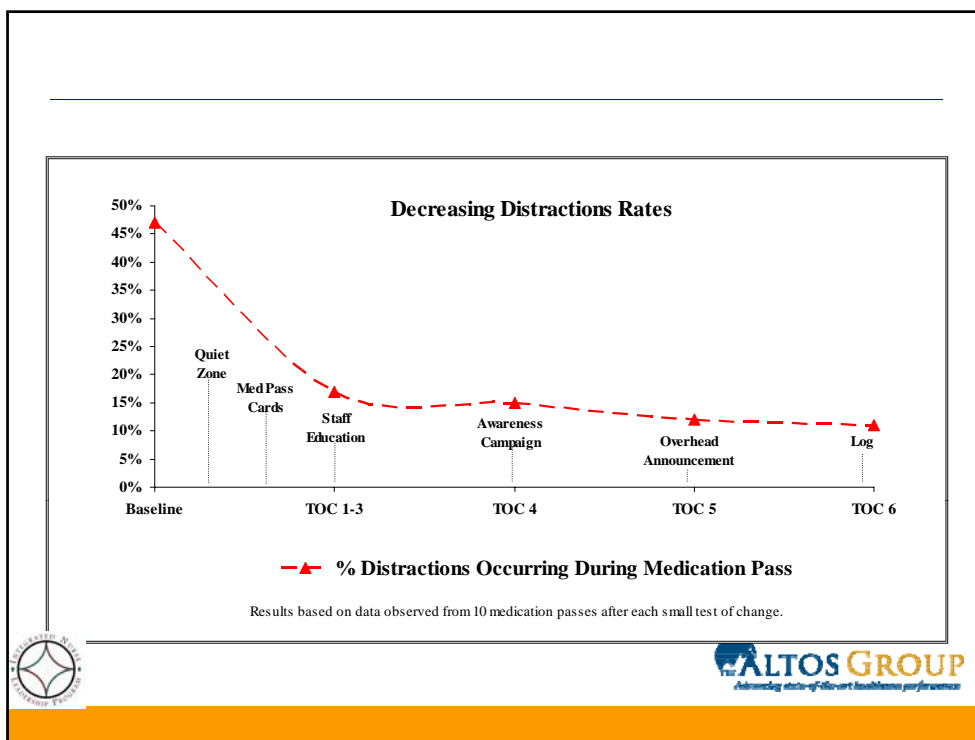
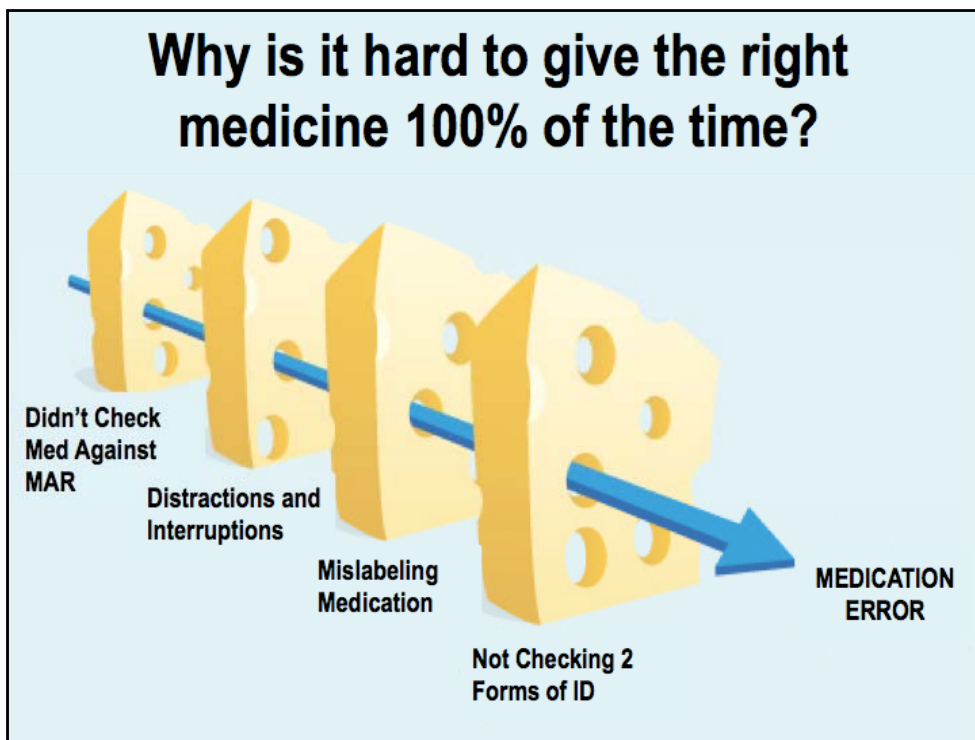


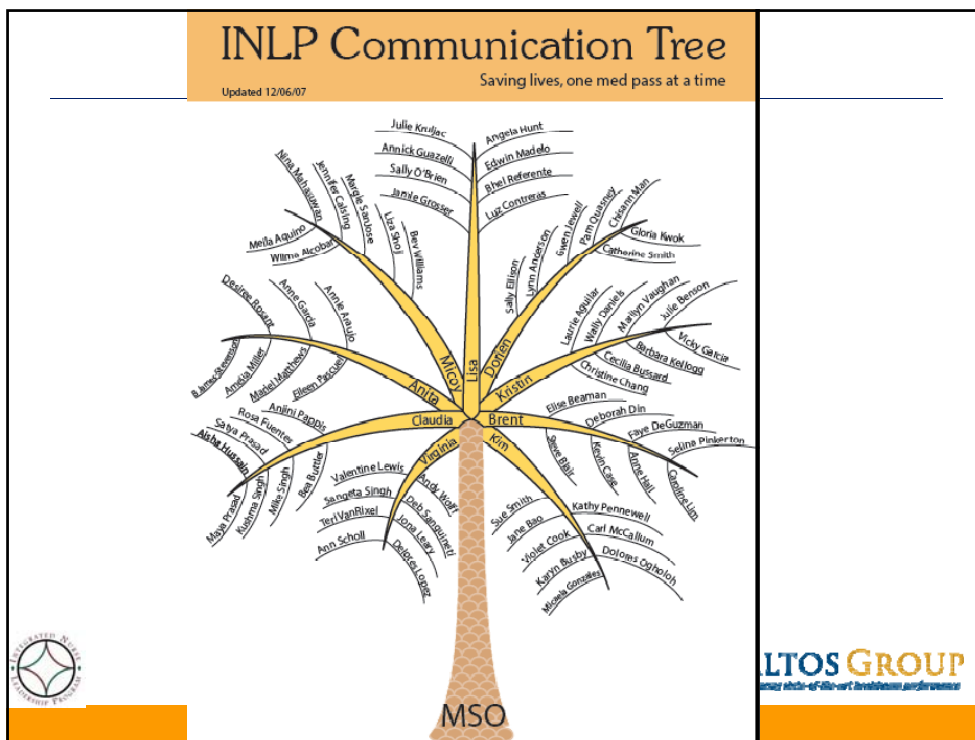
## ERRORS\*

- Unauthorized drug
- Wrong dose
- Wrong form
- Wrong route
- Wrong technique
- Extra Dose
- Omission
- Wrong time
- Drug not available


\*Source: Collaborative Alliance for Nursing Outcomes, CALNOC








## Mini-Posters



**OUR GOAL IS TO BE ERROR FREE**

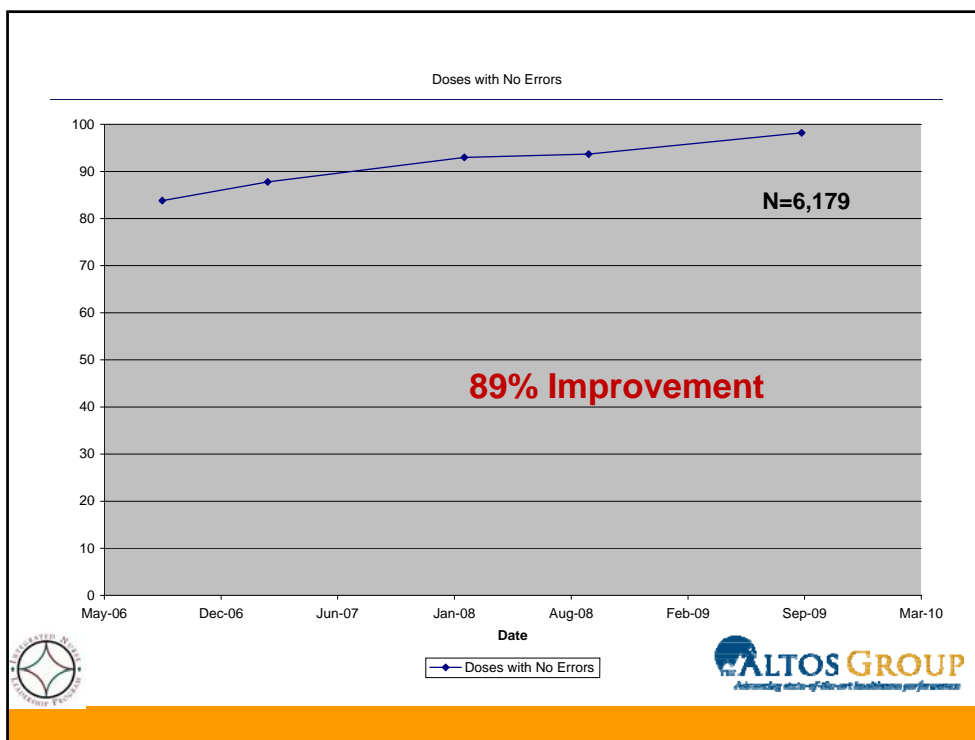
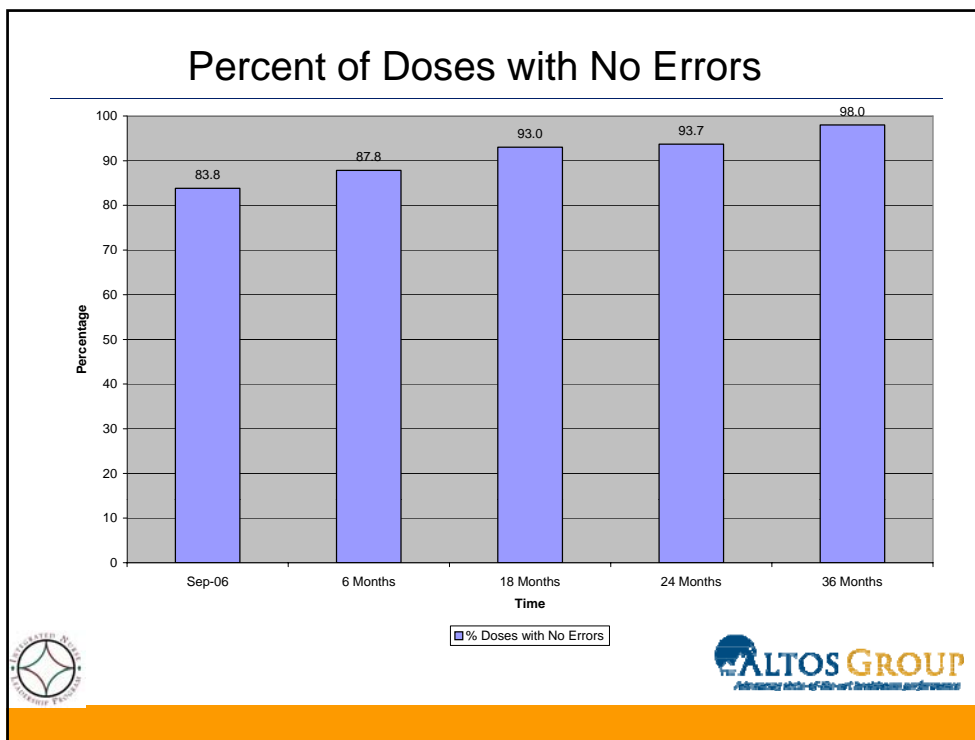
### **MED PASS QUIET TIME**

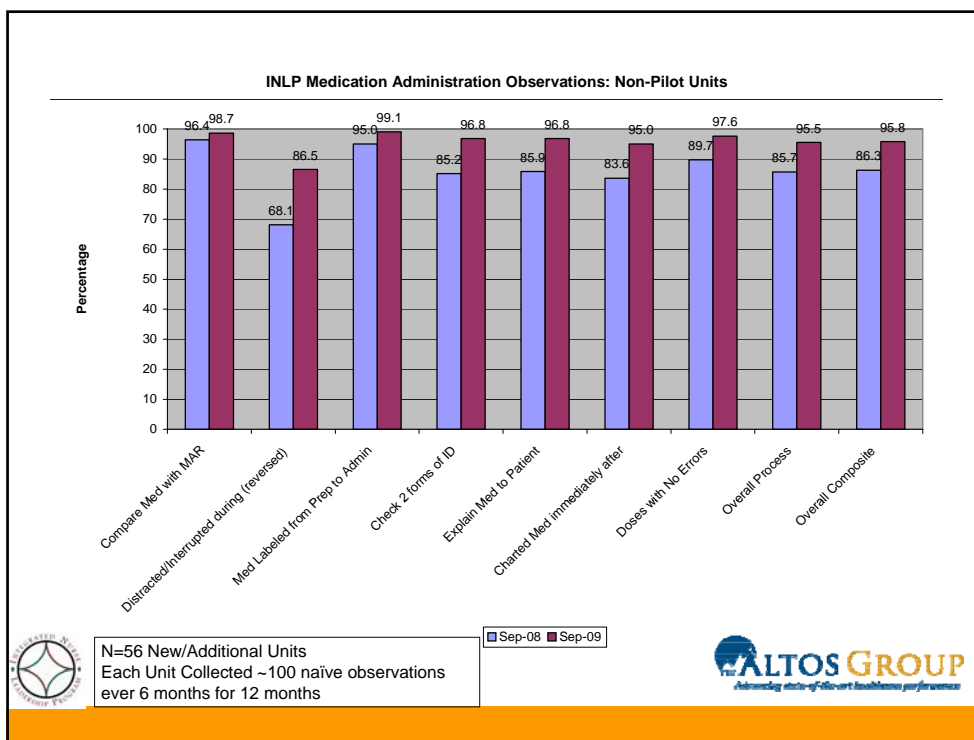
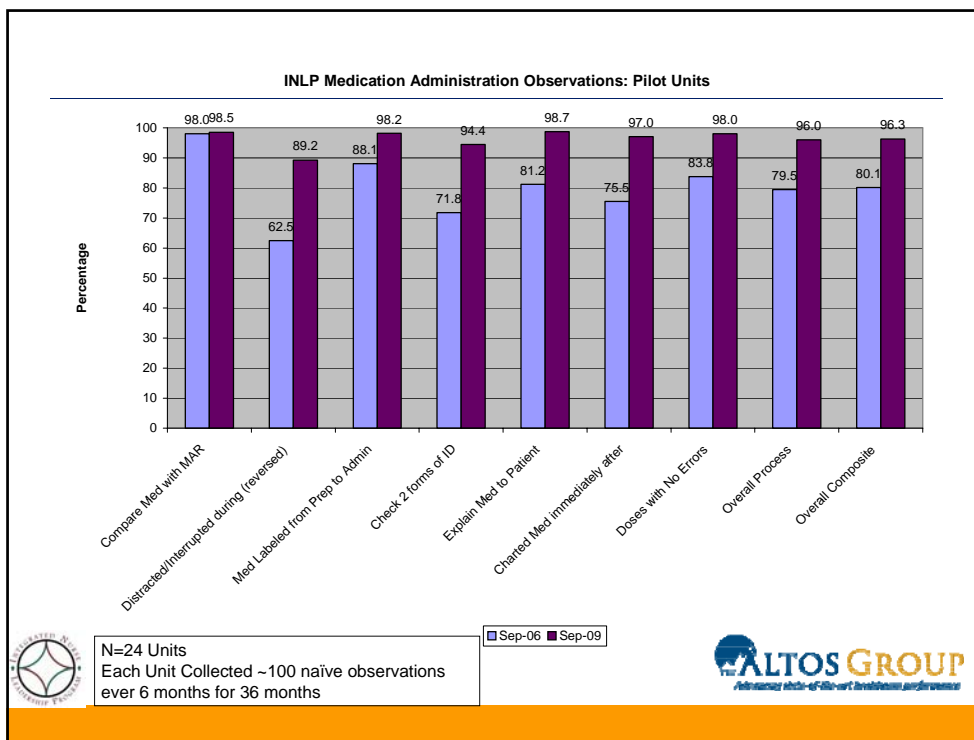
**8am -9am  
NO INTERRUPTIONS**



**YOUR SAFETY COMES FIRST!  
PLEASE DO NOT INTERRUPT  
YOUR NURSES WHEN THEY  
ARE PASSING MEDICATIONS.  
SAVE YOUR QUESTIONS  
UNTIL AFTER 9AM**

**JP**  
*Advancing state-of-the-art health care performance*







## Working Proposition

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- Front-line clinicians should be expertly utilized as the ideal and *ideally positioned* health care provider to create smart, efficient, caring organizations.



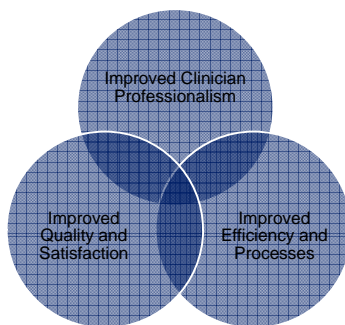
## Value Proposition

### Front Line Clinician

- *Renewed passion for work*
- *Stronger intention to stay in selected profession*
- *Standardization in clinical care (EBM)*
- *Accountability from the ground up*

### Patient

- *Safer care*
- *Better informed consumer*
- *More appropriate integration with current health delivery*



### Organization

- *Culture of high expectations*
- *Reliable Work Processes*
- *Sustained Improvements*
- *Reduce systems' inefficiencies*
- *Workforce satisfaction*



## Leadership Survey Results

**"Has this program helped you develop the skill of 'Taking on leadership responsibilities?'"**

<b>Problem Solving</b>	<b>83.9%</b>
<b>Team Building</b>	<b>83.9%</b>
<b>Planning</b>	<b>83.3%</b>
<b>Goal-Setting</b>	<b>82.1%</b>
<b>Making recommendations based on data and logic</b>	<b>81.1%</b>
<b>Acting with confidence</b>	<b>79.6%</b>



## Result and Value

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- Increases capacity of an organization to accelerate translation of knowledge into action
- New Wine in Old Bottles transformed to New Wine in Less-Old Bottles
- Trained-up employees understanding problem-solving
- Cost savings by standardizing processes and working across departmental silos



## For More Detail....

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- December's Issue: Joint Commission's ***Journal on Quality and Patient Safety***
- March 2010: ***Journal of Nursing Administration*** (JONA)



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# Thank You

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[www.inlp.info](http://www.inlp.info)

