

I've been thinking...



Resolve to start with something achievable
January 2008

I've been thinking about preachers, camels, and commitments.

In response to my November 2007 column, in which I appealed to America's hospitals to lay off the snooze button, wake up, and get on with bedside bar coding, I received a thoughtful letter from the director of pharmacy at a "moderate-sized, rural county hospital." The affirming brother let me know that I was preaching to the choir. However, his evangelization efforts for bar-coded medication administration (BCMA) have not yet succeeded in converting his organization, primarily because their coffers do not contain enough to fund the initiative. Being a former preacher, I was tempted to do something religious, like take an offering.

This guy is not alone. For all bar-code believers out there wandering in the wilderness, scrapping for the resources to get 'er done, I suggest you consider the camel.

You know the fable. No sooner had the Arab lain down to sleep when his camel stuck its nose under the flap of his tent to negotiate a cubic slice of warmth. Once its schnozz was accommodated, the lummoX inched its way in until the Bedouin was out.

Going into a new year, resolve to start with something achievable, even if it's not dramatic.

Bar coding is no small undertaking. With medication administration being the most expensive and demanding component of an overarching initiative, other simpler and less expensive bar-code point-of-care (BPOC) applications might be considered first. These should be easier to slip into your hospital's budget and once in, should in turn contribute to making room for medication applications.

One of my hospital clients is inaugurating its BPOC initiative with glucose monitoring. Turns out that though its glucometers have always been capable of scanning, they've had nothing to scan. So nursing, pharmacy, admitting, and IT services are working together and gearing up for applying bar codes to patient wristbands. In a few months, one benefit of bar coding will have its nose in the door.

While bar-code applications are invaluable for preventing *medication* mistakes, don't forget that they also effectively prevent other serious *medical* mistakes

For example, my client's bar-coding plans call for implementing a specimen-collection application next, which, though it will be more challenging than glucose monitoring, will still be less demanding than taking in BCMA. Seems like a great move to me. Is positive ID for specimen collection any less important than positive ID for medication administration? Ask the 33-year old in New York, who last October had both breasts removed to save her from cancer she never had—all because tissue samples were mislabeled.

Soon after getting this foot in the door with specimen collection, my client plans on adopting bar coding for blood transfusions, stem-cell transplants, and a few other applications before inviting the medication and IV giant in.

After that, there's still plenty more camel to invite in. As a matter of fact, we are working with them on a master plan that calls for applying bar-code labeling and scanning to

- anything collected from patients (e.g., specimens, breast milk, blood, stem cells, vital signs, information, etc.),
- administered to patients (e.g., medications, IVs, chemo, TPNs, breast milk, blood, bone marrow, meals, etc.), or
- any procedure performed with patients (radiation, diagnostic imaging, surgery, implants, physical therapy, etc.)

The idea is to force as much risk out of the system as possible.

Start where you can with what you have. Any gain will be worth it. Perhaps you will discover that if you can somehow take an inch, your administration will see its value and find the ways and means to give you a mile.

Do I hear an "amen"?

A final thought: Before rushing to stick that bar-code snout into the yurt, I recommend hospitals wait on applying bar codes to wristbands until shortly before they are ready to go live with a meaningful scanning application. Putting bar codes on wristbands implies a commitment all should be prepared to act on quickly. The longer scanning is delayed, the more likely a BPOC initiative will not be taken seriously—like Web sites that are forever under construction. Furthermore, lack of execution will unwittingly defer hope and diminish the likelihood of caregivers being enthusiastic when the hospital "finally" is ready to implement a bar-code application. Having bar codes with nothing to read them is akin to one-hand clapping.

What do you think?

A handwritten signature in black ink, appearing to read 'MNU'.

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