

I've been thinking...



Counting Blessings and Learning Lessons
December 2007

I've been thinking about twins, overdosing, and snooze buttons.

It was posted on the Internet, reported on CNN and written up in the LA Times. The story even popped up on the gossip tabloids at our local checkout lines. I'm talking about the drug overdosing of the twins. This time it wasn't about the daring adventures of the Olsen look-alikes flying high on Melrose Avenue. It was about the frightening episode the newborn Quaid's experienced down the street at Cedars-Sinai.

For any of you who were off the planet for the holidays, let me beam you back to reality. On Thanksgiving Sunday, Denis and Kimberly Quaid's newborns' intravenous catheters were mistakenly flushed with a concentration of heparin that was 1,000 times higher than protocol. Fortunately, caregivers discovered the errors and quickly administered protamine sulfate to reverse the heparin's harmful effects. Hospital officials reported that neither patient—thank God—suffered any adverse effects from the event. A year ago, you will recall, several babies in Indianapolis were not so fortunate.

So we count our blessings and are thankful 1) that the Quaid's vulnerable preemies had the benefit of being under the watchful eyes of some of the best caregivers in one of the finest neonatal intensive-care units in the country, 2) that the heparin errors were discovered and antidotes were administered sooner rather than later, 3) so that serious harm was dodged and precious lives were spared, and 4) that the parents are expected to take little Boone and Zoe home before Christmas.

But while we count our blessings, we also do well to learn our lessons.

[ASHP's response](#) to this preventable error certainly summarizes my thinking. Yours too?

"How many wake-up calls do we need?" asked Henri R. Manasse, Jr., Ph.D., Sc.D, Executive Vice President and CEO for the American Society of Health-System Pharmacists (ASHP). "What keeps us up at night is that we know how to prevent these serious errors. Yet here we are again, facing the exact same error that killed three infants one year ago in Indiana."

The statement also recommended that a number of "steps be instituted in all

hospitals.” I hope you will read each of them but I can’t resist underscoring:

Implement barcode bedside scanning technology

While I would not suggest that bar coding is the first or even the most important next step for hospitals to take for preventing heparin errors, I would agree with ASHP that bar coding is an essential path that all hospitals should be traveling— and I would add—without dragging their feet.

Bar-code scanning when stocking drugs in cabinets and administering drugs to babies could have prevented the errors in tinseltown and the heartland, not to mention your home town.

Again, there are other crucial steps that should be taken immediately. See ISMP’s November 29, 2007 Medication Safety Alert: ["Another heparin error: Learning from mistakes so we don’t repeat them"](#).

But I can’t think of one good reason why bar coding at the point of care should not be added to every hospital’s list of nonnegotiables and implemented with alacrity.

There’s another recommendation from ASHP’s response that I want to highlight:

Seek and use knowledge from other institutions that have solved similar problems.

Bar coding is the right thing to do. But it also must be done the right way. Hospitals just getting started have much to learn, and those who have been at it for a while have more to learn.

Each should seek and use knowledge from other institutions’ success. Likewise those who have succeeded should share their knowledge.

To these ends the TerraPharma Project was formed in 2005—to create platforms for the exchange of information that would encourage America’s hospitals to do bar coding at the point of care and to do it right.

TerraPharma’s first platform, [The unSUMMIT for Bedside Barcoding](#), is convening again April 30 to May 2 in Austin, TX. In addition to the finest faculty ever assembled on the subject, The unSUMMIT brings pharmacists, nurses and other hospital leaders together to learn from one another how to safeguard the medication administration process in their facilities. Register your team [online](#).

TerraPharma’s second platform, [pointofcareforum.com](#), is an invaluable online support group, cyber library, and virtual classroom for sharing and finding point-of-care safety solutions. Regardless of where you are in your

bar-coding journey, this is the perfect place to join the discussion and advance the cause with over 800 other members.

Looking back on Thanksgiving, I am grateful that the Quaid's and their hospital survived the errors. Looking around, I'm troubled that 80 percent of our nation's hospitals are still sleeping through the bar coding revolution. Looking ahead to the New Year, I am hopeful these institutions will heed this wake-up call and get with the program.

Tempted to think bar coding can wait? So were our friends in Indiana and Southern California. As Manasse said, "We know how to prevent these serious errors." None of us can afford to push the snooze button on this alarm.

What do you think?

A handwritten signature in black ink, appearing to read 'MNU' with a long horizontal flourish extending to the right.

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