I've been thinking…

Exorcising Unreadable Bar Codes
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I've been thinking about unreadable bar codes, exorcism, and the three R's.

While Googling bar-code medication-administration (BCMA), one results page included an interesting article: "Barcode medication administration demons…"

You bet I clicked on that one. However, because my display window was not opened wide enough, part of the final word was missing—it was *demonstration* not *demons.* Darn. I thought I might have stumbled upon a resource for nurses who swear their bar-code scanners are possessed.

Admittedly, some old scanners out there are awfully slow readers. However, unreadable bar codes are generally the result of poor printing. To prevent slow-reads and no-reads, let's tackle a few of the devils in the details—the three R's.

Reading

Unreadable and slow-read bar codes undermine nurses' confidence in BCMA and ultimately provoke high-risk work-arounds. Enough said.

Righting

Wristbands should be scanned to verify their bar codes are right before they leave admitting. This is important for two reasons. First, to ensure the bar codes are readable; second, to affirm that when the bar codes are scanned, the right patient records appear. Furthermore, bar codes must retain their readability throughout the patient's stay. If not, look for better printers and/or wristband stock until you get it right. Both are readily available.

In pharmacy receiving, bar codes on manufacturer medications should also be verified. Find and fix unreadable bar codes and confirm that all accurately map to your pharmacy's drug data base before putting them into your hospital's supply chain.

When you encounter drugs with unreadable codes, and you will, send 'em back with a piece of your mind. Should a manufacturer's bar codes consistently prove unreadable, report the problem to the FDA here and copy ASHP here. Because you'll still need these drugs, if possible, find another manufacturer whose "unit-dose" packages have bar codes that *are* readable. If not possible, you'll either have to outsource them to a reputable contract repackager or purchase these NDCs in bulk and repackage them in-house.

Finally, all bar codes on patient-specific labels generated from your pharmacy information system must be validated as readable and accurately mapped to the correct patient order. Equally important, I believe your IV preparation processes should force the function of bar-code scanning all ingredients to validate that right doses of the right

drugs are being admixed. Neither the most conscientious nurse nor any state-of-the-art BCMA system is capable of intercepting admixing errors made upstream.

For heaven's sake, let's get it right.

Rithmatic

Research the above packaging options, and you will discover that some cost more than others. Do the math. Weigh cost against potential safety gains and losses. Remember, those unreadable bar codes that encourage nurse work-arounds subtract from BCMA's safety value and add up to costly, indeed hellish, medication errors. Sometimes, as Jon Arbuckle said, "You get what you pay for." Other times you pay dearly for what you get.

Exorcising these wrongs helps protect our patients' rights and provide our caregivers with peace of mind.

What do you think?

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P.S. An hour ago, on a device invented by Steve Jobs, I learned of his death. I'm sad. I'm also grateful for how I have benefitted from his genius and life work. Pecking out these thoughts on a MacBook Pro, I confess, I lean hopelessly on the side of the brain that can't remember which side is creative. Jobs opened the technology door for my kind of brain to enter and flourish. Yes, I am grateful.

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