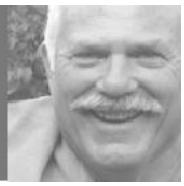
I've been thinking...



Positive-Product Identification
August 2009

I've been thinking about weekends and positive-product ID.

Consider a weekend in the life of a do-it-yourselfer. After my third trip in two days to Lowe's Home Improvement, I discovered that one of the nuts did not match one of the bolts I had purchased to repair my gate. Had another backyard warrior put the nut back in the wrong bin on aisle five? Perhaps it was an unattended child rearranging inventory or an employee whose mind was elsewhere while stocking the bins. It doesn't matter. I had to make a fourth trip. Nuts.

Speaking of fourth, the *fourth* lesson Robert Fulgum says we should have learned in kindergarten fits here: "Put things back where you found them." My Dad has preached and practiced this rule all 87 of his years. "A place for everything," he insists, "and everything in its place." I tell you, the man has CDO—that's obsessive-compulsive disorder arranged in alphabetical order, as it should be. I've often thought, Pops would have been a good pharmacist.

Like nuts and bolts in hardware stores, drugs in hospitals are sometimes placed in wrong compartments (e.g., picking bins in central pharmacies, storage pockets in automated dispensing cabinets, patient cassettes on nursing units).

Consider a weekend in the life of a morphine tablet. Friday afternoon McKesson delivers ten 20-blister packs of morphine ER 60mg tablets, which are immediately put in the pharmacy's narcotics' vault. On Saturday morning, two 20-blister packs are pulled from the vault, transported to the west wing of the second floor, and placed in an automated dispensing cabinet (ADC). In the afternoon, a nurse pulls one morphine tablet from the ADC for Mr. McAffey in 210. By the time she arrives, the pain has subsided, he refuses the med, and she returns the unused blister to the ADC. Sunday morning another nurse pulls the same morphine blister from the ADC and gives it to patient McKinsey in 204. One small glitch—the first nurse accidentally returned the 60mg ER blister to the 60mg SR pocket. Because ER tablets release over 24 hours and SR tablets release over 12 hours, McKinsey receives twice the dose his doctor ordered. That's a trip most patients wouldn't want to take, and if they did, probably shouldn't.

The *right* strengths and formulations of the *right* drugs must always be stored in the *right* locations. Failing any of these rights is a setup for violating the patient's right to get the correct medication.

As meticulous as pharmacists are, they do make errors. Even my dad's made his share of return trips to the hardware store after schlepping home the wrong item, and it wasn't always someone else's fault.
Consider a weekend in London. Americans do well to heed the painted warnings underfoot between the platforms and trains throughout the color-coded labyrinth of the famed Underground—MIND THE GAP. Perhaps more importantly, pedestrians above ground do well to heed the painted curbs at nearly every intersection—"LOOK RIGHT." I've had my close calls with those stealthy red double-deckers zipping along the British side of the street. One misstep can ruin a trip to the royal city.

For fifteen years, like a stuck record, I've warned about the distance and distractions between points of dispensing and the points of administering medications. I've appealed to hospitals to implement bar-code verification scanning at the point of care for matching the right patients with the right drugs (i.e. to MIND THE GAP). However, I have not been as diligent in appealing to pharmacists, technicians, and nurses to employ bar-code scanning to positively ID products at every storage and retrieval point on the drugs trip from the McKesson delivery at the loading dock to patient McKinsey in 204W.

Naively, some healthcare professionals have imagined that if they've implemented bar-code verification systems at the point of care, they can cut themselves some slack during the distribution/dispensing legs of the journey. I'd say that's a bit like London vacationers minding the gap on train platforms while failing to look right at intersections, with a slight difference—someone else's life is at stake.

Positive-product ID all the way.

What do you think?

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