

I've been thinking...



The Point of Care
March 2007

I've been thinking about points.

Ah, the ambiguity of the English language. Without more context, how could you possibly know what I have in mind by *points*?

I'm writing this article from the skies above one of the Dakotas—roughly, the halfway *point* between Boston and Seattle. A moment ago, I was wondering how many *points* I've amassed in my Marriott Rewards account. Right now, another road warrior is rehearsing a presentation on his laptop, the power *points* of which are large enough for me to read from three rows back. However, that's all beside my *point*. I'm really thinking about the *point of care*.

Even the term *point of care* is capable of transporting multiple meanings. I've asked nurses, "What is the point of care?" only to have them assume I was inquiring about the purpose of care. Their common answers went something like, "To bring relief and promote healing." However, when I've provided more context by asking, "In the medication-use process, where is the *point of care*?" the almost universal answer has been, "It's the point at which a caregiver administers medication to a patient." I have not had anyone say that the point of care was at an automated-dispensing machine (ADM).

Nevertheless, during the 1990s, pharmacy automation vendors, pharmacists, nurses, and even the literature commonly referred to ADMs as *point-of-care systems*. True, ADMs store medications up on the floor where nurses care for patients rather than down in the basement on pharmacy shelves. But, in my opinion, calling drug cabinets *point-of-care systems* was confusing, if not misleading. Don't get me wrong. I appreciate the value and advocate the use of ADMs for limiting access to medications that have been ordered for patients only after they have been approved by pharmacists and are actually due. But the fact remains, an ADM is a *point of dispensing* (A), while the point of care (B) is generally a good trek down the hall with numerous opportunities for interruptions in between.

With today's focus on bar-code point-of-care systems (BPOC), I think we are well on our way to getting over the use of *point of care* for anything other than the time and place where medications are actually administered to the patient. More importantly, we are respecting and wanting to close the gap—with accompanying risks—that exists between points A and B.

Several decades ago with the advent and acceptance of the unit-dose drug-distribution method (UDDD), two main dispensing paradigms emerged.

Many early adopters delivered medications to patient-specific cabinets called “nurse servers”—generally located in the walls just outside or inside patients’ rooms. Eventually, most hospitals opted instead to load meds in patient-specific cassettes in carts near nursing stations. Medication nurses wheeled these carts down the halls, if not into the rooms, to administer meds to all the patients on their wards. Over the years, as the practice shifted from one nurse medicating many patients to each nurse medicating a few patients, carts tended to stay put near nursing stations. Medications were carried between points A and B in nurses’ pockets.

The same is true today in an increasing number of hospitals that have eliminated carts in favor of nurses retrieving most of their patients’ medications from ADMs. In some instances, because it takes longer to pull meds from an ADM than from a manual cart, nurses are dispensing medications for several patients at a time. This means they must remember that Smith’s are in the left pocket, Jones’s are in the right, and Brown’s are in hand. The whole thing makes me think of Columbo searching through his pockets for a matchbook.

So, how do we close the gap and reduce the risk?

One solution is to implement bar-code-verification systems at the bedside. Another solution is to move the point of dispensing closer to the point of administering. Each can help prevent nurses from giving wrong medications to their patients. The good news—it doesn’t have to be an either/or.

Even when hospitals close the safety gap with BPOC, they still may want to close the logistics gap between the point of dispensing and administering. Two approaches in this regard seem to be getting the most attention. One is to dust off the nurse servers. In this case, patient-specific cassettes are still filled in the pharmacy, but instead of being delivered to centralized carts, they are dropped into locked cabinets in patients’ rooms. Pharmacy often gets *points* with nursing for this sole-saving move. While most of today’s nurse servers are manually locked compartments, I envision the day when they will be outfitted with electronic locks and user-tracking software.

Another solution is getting a fair amount of traction. Hospitals are taking automated mobile carts for a spin. Outfitted with BPOC computing devices and bar-code scanners, these carts hold four to eight patient-designated cassettes, which are electronically locked. In some cases they are configured so that only the drawer of the patient being scanned is released for obtaining medications.

Most nurses love it when the points of dispensing and administering become next-door neighbors. Many think it cuts down on borrowing from Peter’s

cassette to medicate Paul. Some even believe the move helps them better achieve the *point* of caring for patients.

I'm interested in your *point* of view.

A handwritten signature in black ink, appearing to read 'Mark Neuenschwander', with a stylized, cursive script.

Mark Neuenschwander

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