The state of IV compounding. It’s time for a new standard.

A standard day in manual IV preparation

<table>
<thead>
<tr>
<th>Process</th>
<th>Inaccuracy</th>
<th>Label sort</th>
<th>Dose preps.</th>
<th>Pharmacist check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose calculation</td>
<td>75% of IV errors</td>
<td>63%</td>
<td>87%</td>
<td>57%</td>
</tr>
<tr>
<td>Dose dispensed</td>
<td>100%</td>
<td>85%</td>
<td>82%</td>
<td>55%</td>
</tr>
<tr>
<td>Label error</td>
<td>100%</td>
<td>95%</td>
<td>92%</td>
<td>65%</td>
</tr>
<tr>
<td>Product labeling</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>57%</td>
</tr>
<tr>
<td>Incorrect drug</td>
<td>90%</td>
<td>89%</td>
<td>98%</td>
<td>74%</td>
</tr>
<tr>
<td>Wrong dose</td>
<td>100%</td>
<td>90%</td>
<td>85%</td>
<td>55%</td>
</tr>
</tbody>
</table>

- Pharmacists manually interpret syringe, mixing and add-on medications.
- Calculating error often done by hand, resulting in human error.
- Pharmacist verification may not be timely.
- Pharmacists are not able to remove redundant steps.
- Pharmacists are often responsible for documentation.
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Real risk, real consequences…

- More patients and more intricate treatment regimens lead to increased risk of IV medication errors.
- In Oregon, a woman received a paralyzing agent instead of the standard 0.9% solution. 11
- In a NICU as a result of using 23.4% NaCl solution instead of the standard 0.9% solution. 11
- More patients have experienced a fatal overdose due to the chemotherapy medication non-compliance.
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Pharmacies frequently lack a standardized automated system, resulting in non-value steps and inefficiency of IV-order processing and compounding.

- Historical cost associated with managing pharmacy errors is estimated at 10% to 12% of total hospital expenditures. 10
- Estimated viable drug re-utilization of returned patient-specific drugs and wrongly prepared meds. 13
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The trouble with waste

- $1 million
- 13% of volumetric measured doses
- 69%
- Mail and drugs account for the majority of a pharmacy’s budget.
- 14% of hospitals experienced a patient event involving pharmacist that preparation is ready for IV room.
- 30% of hospitals experienced a patient event involving pharmacist that preparation is ready for IV room.
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A “risk-a-tot” approach to IV compounding

- Automating steps to reduce human error, inefficiency and waste.
- Product labeling
- BD Cato® Medication Workflow Solutions
- 49 self-reported versus 296 errors
- Reducing the SBP drug shortages on the U.S. market.
- Cuts down the 35% of medication re-ordering, reducing hospital costs.
- Provides an automated approach to IV compounding.
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Ready to advance IV compounding in your institution? Visit bd.com/cato