should have been performed in patients prior to dronedarone treatment (GROUP A), those who started the treatment before the alert (group B), and finally patients who discontinued this semester (GROUP C). In group B patients we checked whether the ongoing controls specified in the alert had been done. Similarly, in Group A patients we checked whether the start of treatment controls had been done (renal and hepatic function before and the week of the start of treatment). Serum creatinine concentration was considered valid as a cheque of renal function; transaminase levels were suitable for the liver function test. Selene (clinical history management software) and Agora Plus (primary integrated medical record-hospitalisation management software) were used to retrieve the serum concentrations.

Results We examined 72 clinical histories. Group A contained 17 patients. Only 5% had liver and kidney function tests as required by the Competent Authority. In group B (48 patients), 31.2% had none of the controls required. Only 6.2% of patients had a creatinine cheque. Only 4.1% of patients had a liver function cheque. In Group C with 7 patients (two deaths), 71.4% had no analytical controls of any kind, and in only 14.2% were renal function tests performed.

Conclusions The degree of compliance with tests required by the Health Authority in patients taking dronedarone is very low. It seems necessary to review and improve the system of drug alerts to physicians, and the pharmaceutical care of patients seen in primary healthcare. Computer systems such as the Agora Plus that integrate primary and hospitalisation data are critical for this type of monitoring.

No conflict of interest.

GRP-119 MOST FREQUENT DRUG-RELATED EVENTS DETECTED BY PHARMACEUTICAL ANALYSIS OF COMPUTERIZED PHYSICIAN ORDER ENTRY AND PROPOSED SOLUTIONS

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Background In 2012, Toulouse University hospital implemented a Computerized Physician Order Entry (CPOE) system in two digestive surgery departments (41 inpatient beds). Clinical pharmacists in the wards contribute to safeguarding the medication process by reviewing prescriptions.

Purpose To highlight recurrent and avoidable drug-related problems identified by pharmaceutical analysis of CPOE and to raise physicians' awareness regarding these prescription problems.

Materials and Methods From April to July 2012, Pharmaceutical Interventions (PIs) concerning prescription problems were recorded in the CPOE according to the codification defined by the working group of the French Society of Clinical Pharmacy. We extracted the following data from the CPOE: drugs, type of problems and PIs. We identified the main prescription problems and drugs involved. After data analysis, preventive measures were submitted to the physicians.

Results 2396 prescriptions were analysed and 450 Pharmaceutical Interventions (PIs) were accepted by physicians (18.8%). Main prescription problems concerned analgesics (52 PIs made): inappropriate administration and dosage errors; heparins (31 PIs): dosage errors; antiemetics (24 PIs): dosage errors and drug-drug interactions; antibiotics (16 PI): inappropriate prescription. To prevent these problems, a multi-disciplinary group was set up with physicians, nurses and pharmacists. This group has reviewed standardised order sets and has developed a pocket guide to help new residents while prescribing.

Conclusions This study describes the most frequent CPOE problems. Communication and collaboration with physicians and nurses are the key to reducing avoidable adverse drug events and to safeguarding CPOE.

No conflict of interest.

GRP-120 MULTIDISCIPLINARY INTERVENTION: INTRATHECAL AND INTRAVENTRICULAR CHEMOTHERAPY IN PAEDIATRICS

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Background A communications system was designed after notification of two errors in two months, in intrathecal and intraventricular chemotherapy in paediatric oncohaematology: prescribing by protocol, consultation sheet standardised and computerised; transcription using the Farmis integrated system for chemotherapy and preparation centralised in the pharmacy after standardisation, and administration with a double cheque. Functions were established and detailed in each process to all groups involved.

Purpose To conduct a retrospective observational descriptive study to cheque compliance with the intrathecal and intraventricular rules at each level: prescription, transcription, preparation, distribution and administration and to analyse any change in the errors made with intrathecal and intraventricular chemotherapy before and after the new system was implemented.

Materials and Methods Each of the processes in the system was tracked, during the year after the intervention – July 2011. Prescriptions were analysed through electronic medical records, Farmis, nursing and pharmacy records.

Medicines error reporting to the Safety Commission was monitored during the year after the implementation. The error rate was determined by comparing the two months prior to the intervention.

Results 167 prescriptions were checked, 133 intrathecals and 34 intraventriculars. The professionals involved were monitored 100% in all processes, except the administration checklist by neurosurgeons, which was only 62.5% checked. The error rate reported by number of prescriptions went from 0.14 in the previous two months to 0.006 in the year after intervention.

Conclusions There has been high system monitoring by all professionals involved. The number of medicines errors became lower in the post-intervention period. Thus, centralization and standardisation of intrathecal and intraventricular chemotherapy has helped increase patient safety.

No conflict of interest.

GRP-121 MULTIDISCIPLINARY MONITORING OF PSYCHIATRIC MORBIDITY OF HCV-INFECTED PATIENTS TREATED WITH INTERFERON AND RIBAVIRIN

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Background Treatment of hepatitis C virus (HCV) infection with pegylated interferon and ribavirin may induce psychiatric disorders, which may result in poor adherence and response to antiviral treatment.