should have been performed in patients prior to dronedarone treat-
ment (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 consid-
ered valid as a cheque of renal function; transaminases were suit-
able 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 creati-
nine cheque. Only 4.1% of patients had a liver function cheque. In
Group C with 7 patients (two deaths), 71.4% had no analytical con-
trols 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.

**Conclusions** This study describes the most frequent CPOE prob-
lems. Communication and collaboration with physicians and nurses
are the key to reducing avoidable adverse drug events and to safe-
guarding CPOE.

No conflict of interest.

**Background** A communications system was designed after notifi-
cation 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 intraventricu-
lar rules at each level: prescription, transcription, preparation, distrib-
ution 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. Prescrip-
tions 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 deter-
mined by comparing the two months prior to the intervention.

**Results** 167 prescriptions were checked, 153 intrathicals and 34 intraventriculars. The professionals involved were monitored
100% in all processes, except the administration checklist by neuro-
surgeons, 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 profes-
sionals involved. The number of medicines errors became lower in
the post-intervention period. Thus, centralization and standardisa-
tion of intrathecal and intraventricular chemotherapy has helped
increase patient safety.

No conflict of interest.