than 2 mg. Nobody was given more than 9 mg. In total, 350 mg of atropine was immediately necessary on the site of the attack, equivalent to 350 phials of 1 mg. In our simulation, the time for access and preparation of the antidote was about 10 minutes from the moment of the alert. The transfer and distribution time to the site was less than 15 minutes due to favourable road access, geographical factors and the short distance from the station to the storage facility.

Conclusions The pharmacist is responsible for immediate availability, accessibility and distribution of the antidotes to the site of emergency, and awareness of appropriate treatment.

No conflict of interest.

**Background** Electronic prescribing (EP) systems have been recognised as successful in reducing chemotherapy prescribing errors. However, electronic prescriptions are unlikely to prevent all errors, and new types of errors may emerge.

**Purpose** To assess prescribing error rates and identify new error types and their causes with the implementation of an electronic prescribing system for ambulatory cancer patients at a London Cancer Centre.

**Materials and Methods** A service evaluation was conducted in two parts, covering two different strategies for interception of prescribing errors - prospectively by pharmacists during a 2-week period, and retrospectively using data from the pharmacy EP telephone helpline service, over 41 weeks.

**Results** The overall rate of error-containing prescriptions was estimated to be 6%.

In the prospective part, 32 errors were identified from 571 electronic chemotherapy prescriptions. Most commonly committed errors were chemotherapy drug dose adjustments (13; 41%) and weight omissions (11; 34%).

In the retrospective analysis, 95 of 141 errors (67%) were 'selection errors', classified mainly as 'work-arounds' (26; 18%), 'wrong commands' (35; 25%), or 'wrong fields' (27; 19%). 65 errors (45%) were related to scheduling a chemotherapy or supportive drug or regimen.

Electronic system-related causes of prescribing errors were recognised in 4 of 32 cases (13%) in the prospective part, and in 89 of 141 cases (63%) in the retrospective part. It was estimated that with implementation of technical solutions and additional prescriber training, 58% of these errors could be prevented in the future.

**Conclusions** The estimated rate of chemotherapy prescribing errors was 6%. A number of different errors, specific for electronic prescribing, were identified, with a thorough explanation of how various errors may have occurred. Future larger scale studies are needed to confirm prescribing error rates, and to possibly identify others, previously unrecognised, types of chemotherapy prescribing errors.

No conflict of interest.

**Background** In the post-marketing setting, spontaneous reporting is an important tool for the surveillance of Adverse Drug Reactions (ADRs). However, underreporting is a major limitation of a pharmacovigilance system. Several studies showed that ADRs may cause hospitalisation resulting in an increase in hospital stays and costs.

**Purpose** To gather information on the extent and frequency of ADRs at Careggi University Hospital, and to identify unreported ADRs to the Pharmacovigilance Office, using the hospital discharge records.

**Materials and Methods** We analysed the hospital discharge records from January 2011 to June 2012. In particular, we considered those records with a Drug Related Group (DRG) classification related to allergic reactions, poisoning and toxic effects of drugs (DRGs from 447 to 451). We included in our analysis records referring to poisoning, according to the new pharmacovigilance legislation in force from July 2012. Our research gave us information about the number of suspected reactions, but it didn’t provide specific information on the patients and the seriousness of the reaction.
Results We obtained 346 records related to the DRGs selected: 101 (29%) ADRs and Testing Oral Exposure to Drugs, 91 (27%) poisoning, 20 (6%) drug abuse, 7 (2%) reactions to foods and 97 (28%) unspecified events. It was possible to identify the drug involved in only 51 records: antibiotics, NSAIDs, chemotherapy agents, local anaesthetics, opioids and immunoglobulin were the agents mainly reported. Only 2 cases had been reported to the Pharmacovigilance Office and entered in the Italian National Pharmacovigilance Database.

Conclusions Our survey shows a mismatch between the ADRs documented in the hospital discharge records and those actually reported to the hospital’s Pharmacovigilance Office, highlighting the problem of under-reporting. The data could be useful for implementing measures to raise awareness among health care professionals and to spread the culture of drug safety.

No conflict of interest.