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Letter To The Editor

Safety of onco-hematological patients: a mobile target

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Abstract: The pharmacy profession deeply mourns the events at Burgos Hospital and calls for reflection on the prescription–validation–preparation–administration of chemotherapy process to enhance patient safety. Medication errors, particularly in chemotherapy, are linked to insufficient experience, staffing shortages, and limited safety culture. Key preventive measures include process standardization, full medication traceability, mandatory gravimetric controls, and electronic systems with multiple checks. Specific staff training, delegation of secondary tasks, and workload assessments are recommended to ensure safety. Patient safety requires a multidisciplinary approach with committed institutional leadership.

Keywords: Palabras clave como MeSH TERMS: Medication Errors; Patient Safety; Pharmacy Service, Hematology; Oncology Service, Hospital.

INTRODUCTION

Dear Editor,

Our profession has received with profound sorrow and solidarity the events that occurred at Burgos Hospital [1]. Hospital pharmacists, particularly those validating onco-hematological treatments, deeply empathize with those affected. This situation calls for urgent and comprehensive reflection on the prescription–validation–preparation–administration process to identify weaknesses, implement improvements, and ensure maximum patient safety.

The report To Err Is Human [2] estimated that 44,000–98,000 hospital deaths annually result from errors, including 7,000 related to medication administration. The GEDEFO document Prevention of Medication Errors in Chemotherapy [3] defined chemotherapy medication errors (CME) and identified contributing factors: insufficient knowledge or experience, staffing shortages, and limited safety culture. Later publications [4] emphasized traceability and control systems as key preventive measures. Therefore, process standardization across hospitals is essential.

Ensuring full medication traceability—national drug code, batch number, barcode verification inside and outside the compounding cabinet—as well as preparation traceability and mandatory gravimetric control is critical. Electronic prescribing systems should incorporate double or triple checks at protocol creation and other high-risk stages, establishing robust safety barriers.

Recruitment processes requiring specific training would reduce reliance on peer-based on-the-job training, which increases error risk in already overloaded environments. When pharmacists perform multitasking roles, protocols must allow delegation of secondary tasks to protect concentration and minimize interruptions during validation.

A European survey should assess human resources, materials, and process controls to define safe workload ratios for pharmacists and compounding staff, including regulated rest periods. In its first White Paper [5], SEOM established one HP with exclusive dedication from 40 oncology administrations per day, without specifying a ratio. Patient safety is a moving target that demands continuous adaptation. Preventing CME requires a rigorous, multidisciplinary, institutionally supported system in which leadership assumes full responsibility. As Denham stated, patient safety begins and ends with leadership.

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