Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.180, November 2021

Incorrect Prescription of Meylon Injection 250 mL Preparation

Three cases have been reported in which a prescription order was issued in error for Meylon Injection 250 mL preparation, causing patients to experience hypernatremia and heart failure (information collection period: from January 1, 2019 to September 30, 2021). This information was compiled on the basis of the content featured in the Analysis Themes section of the 65th Quarterly Report.

Cases have been reported in which a prescription order was issued in error for Meylon Injection 250 mL preparation and the drug was administered to the patient, affecting them.

Purpose	Intended Prescription	Incorrect Prescription	Number of Days of Administration	Main Background Factors
Treatment of peripheral vestibular dysfunction	Meylon Injection 7% 20 mL 2 times/day	Meylon Injection 7% 250 mL 2 times/day	6 days	Selected without checking specification on the order screen
Treatment of tumor lysis syndrome	Meylon Injection 7% 20 mL + POTACOL R Injection 2 times/day	Meylon Injection 7% 250 mL + POTACOL R Injection 2 times/day	4 days	Selected without checking after preparations were displayed on the order screen in the sequence 250 mL preparation, 20 mL preparation
Prevention of contrast-induced nephropathy	Sodium Bicarbonate Injection 1.26% bag 1,000 mL 180 mL/h 1 hour each before and after examination	Meylon Injection 8.4% 250 mL 4 bags 180 mL/h Before and after examination	1 day	Searched for Meylon and selected bag preparation displayed on the order screen

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Case

The physician intended to administer Meylon Injection 7% 20 mL mixed with POTACOL R Injection 500 mL two times/day. When the physician entered the order, the preparations were displayed with Meylon Injection 7% (250 mL/bag) on the upper row and Meylon Injection 7% (20 mL/A) on the lower row. The physician selected the upper row without checking the specification or dosage form. The nurse felt that mixing in Meylon Injection 7% 250 mL was odd, but did not check with the physician. Using an infusion bag, the nurse mixed the Meylon Injection 7% 250 mL and POTACOL R Injection 500 mL on the first and second day, while the pharmacist mixed the drugs on the third and fourth day. On the fourth day of administration, after a nurse reported the occlusion of the peripheral venous line, the physician checked the patient and noticed that Meylon Injection 7% 250 mL was being administered. The patient suffered heart failure and mild pulmonary edema.

Preventive measures taken at the medical institutions in which the events occurred

- **Display the specification before the drug name on the order screen.**
  Example: [250 mL] Meylon Injection 7%
- **Display an alert when prescribing Meylon Injection 250 mL Preparation.**
  Example: 250 mL preparation: Risk of hypernatremia due to overdose

The measures above are examples. Please consider initiatives suitable for your own facility.

Key Preventive Measures

- **Restrict the clinical departments that can issue a prescription order for Meylon Injection 250 mL Preparation and the departments/wards to which it is dispensed, based on the purpose of use and past use of this preparation.**

(Comprehensive Evaluation Panel)

* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of the "Comprehensive Evaluation Panel" to prevent the occurrence and recurrence of medical adverse events. See the Project website for details.
  http://www.med-safe.jp/
* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.
* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

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