Permission to print:	Yes
Near Miss or Accident	Near Miss
Type of incident:	Management
Catagory	Fatigue
Knowledge Error	No
Protocol Issue	No
Rule Error	Yes
Skill Error	Yes
Team Issue	No
Violation	Yes
Chance Chance event:	No
Description:	Set up for 27kg VSD, clear prime. Added Albumin, heparin bicarb, cefazolin [prior to goning into the operating room]. I don't usually add cephazolin until time-out but was tired and wanted coffee, distracted. Went into theatre and continued setting up, mentioned to anaesthetist about the cephazolin and he said patient had severe cephalosporin allergy. [I] Had assessed patient and notes previous day and had not noted any allergies.
Contributing factors:	Had worked until 2230 the previous night, home 2300 and very little sleep, no 12 hr break as not enough staff and didn't want to cancel paed case. In at 0700, quite tired. [The .conditions of work state a 12 hour break is to be taken before the next rostered duty]
Corrective action:	Discuss with coordinating perfusionist who suggested washing out. I had not done that before but after d/w anaesthetist decided to go ahead with help from coordinator, advised surgeon of delay and the reason. Circuit washed with 8+ litres of plasmalyte and then additional drugs added, patient very stable whole time.
Preventative action plan:	Take my 12 hr break regardless of cancelling case. Perfusion staff reminded of the necessity to observe the 12 hour break condition.
Manufacturer advised:	No
Discussed with team:	Yes
Ext Authority Advised	No
Patient outcome variance f	Nil