### 2020 Drug/medication

<table>
<thead>
<tr>
<th>Permission to print:</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Incident type</td>
<td>Good Catch No Harm Incident</td>
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<tr>
<td>Type of incident:</td>
<td>Management</td>
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<td>Category</td>
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**Description:**

Overnight set up with a 4:1 cardioplegia system was used to do a case with del-Nido cardioplegia. Del-Nido cardioplegia was made and hung onto the pump. The pump was deaired and wheeled into the operating room. Checklist was completed and lines were divided. Patient was put on bypass. Cardioplegia was started and arrest was attained with 400mls given, quick glance was made to see if all was looking ok, however it was discovered the cardioplegia tubing was not switched for 1:4 delivery. Immediately the surgeon was informed and help was obtained from coordinator to switch the tubing to complete delivery of de-Nido cardioplegia. Cardioplegia was stopped, tubing was switched, arterial pump was stopped and pump was recirculated for any GME for a minute or so. Once satisfied main pump was started and cardioplegia delivered and continued case as planned.

**GOOD CATCH - what we**

- A thorough check of pump and tubings after x-clamp. Help from supervisor (n plus 1)
- Clear communication between surgeon, perfusion.

**Preventive actions**

- Adapted the checklist for a specific Del Nido tubing check
- A proper checklist specifically for del-Nido or a checklist that indicated if tubing was switched.

**Manufacturer advised:** No

**Discussed with team:** Yes

**Ext Authority Advised** No

**Hospital incident filed:** Yes

**Knowledge issue** No

**Rule issue** Yes

**Skill issue** No