

## 2023 Drug/Medication (cardioplegia)

Permission to print:	Yes
Category	Drug / Medication
Incident type	Good Catch No Harm Incident
Duration of incident:	minutes
Description:	<p>Subsequent to an adult CPB (98 Kg) where Del Nido Cardioplegia was used with single roller combined ¼" - 1/8" ID tubing, it was noted on setup for new case that the S5 cardioplegia roller pump tubing size setting had been reset from the dual tubing ( ¼" ID 1/8" ID) to the ¼" ID setting and this had gone unnoticed despite a section on the check list for the tubing size settings. (left unchecked for the case in question). The result was that the requested total dose of cardioplegia to be delivered (initially 1200ml, and revised at time out to 1500 ml) was a delivered dose of 1200ml v the 1500ml. Early asystole was achieved and there was spontaneous return of rhythm on removal of the cross clamp. The patient post operative course was routine. It is possible the setting change was made where the cardioplegia pump was used for MUF at the end of a preceding case and not reset for cardioplegia delivery. It could not be verified that this was isolated to one case.</p>

**GOOD CATCH - what went well** The error resulted in a non significant variation in cardioplegia dose.

**What could we do better** Closer attention to that particular part of the checklist.

**Preventive actions** Discussed adherence / attention to the pump setting checks with the with the team and look at repositioning the tubing size check on the checklist.

**Type of incident:** Management

**Hospital incident filed:** No

**Ext Authority Advised** No

**Discussed with team:** Yes

**Patient outcome varianc** Nil

**Knowledge issue** No

**Rule issue** Yes

**Skill issue** No