2023 Drug/Medication (prime)

Permission to print:	Yes
Category	Drug / Medication
Incident type	Good Catch No Harm Incident
Duration of incident:	minutes
Description:	While preparing for a paediatric bypass case, the assisting perfusionist (new to paediatrics) drew up 5000iu/ml heparin rather than 1000iu/ml heparin. This resulted in 7500iu heparin going into the prime rather than 1500iu as prescribed on the patient's drug add sheet. The primary perfusionist noted the heparin vial in the drug container [on the heart lung machine] not long after addition to the prime. The circuit was drained, washed out and reprimed with the appropriate heparin. The anaesthetist was informed. The case proceeded without incident.
GOOD CATCH - what went well	The procedure is for drug add vials to be placed in a specific container on the HLM for secondary checking. The larger heparin vial was noted at that point and situation was remedied without delay to surgery or harm to patient.
What could we do better	The primary perfusionist should have sighted the vial before administrating the heparin into the prime (not after) Better training of people new to paediatrics is required
Preventive actions	Checklist for training assisting perfusionists .Double checking drugs as per protocol before administration Highlighting the prime sheet with strength of heparin
Type of incident:	Management
Hospital incident filed:	No
Ext Authority Advised	No
Discussed with team:	Yes
Knowledge issue	Yes
Rule issue	Yes
Skill issue	No
Patient outcome varianc	Nil