

ISO 80369

Small-bore connectors for liquids and gases in healthcare applications



Presenter/Speaker Personal Disclosure

- > Presenter's Name: Rikki Lynn Doyle
- > I have no current or past relationships with any commercial entities
- > Speaking Fees for current program:
 - I have received a speaker's fee from PTSA for this learning activity



Presentation Structure

- > What is ISO 80369?
- > A Short History of the Luer
- > Describe Tubing Misconnections
- > ISO 80369 and Patient Safety
- > ISO 80369 standard series: The 7 parts
- > Alberta Health Services Transition to ENFit
- > Test your knowledge
- > Q&A



Learning Objectives

By the end of this presentation:

> 1. Participants will learn the purpose and scope of ISO 80369

2. Participants will learn how compliance with ISO 80369 can improve patient safety

> 3. Participants will learn what Alberta Health Services has done to work towards meeting the ISO 80369 standard



What is ISO 80369?

- International Organization for Standardization
- > 80369 is a series of medical device standards that cover small bore connectors for direct individual patient care
- The standards were developed to improve patient safety

ISO 80369-1

• General Requirements and Overview

ISO 80369-2

- Breathing Systems and Driving Gases
- Airway

ISO 80369-3

- Enteral and Gastric
- Stomach
- ENFit

ISO 80369-4

- Urinary Collection
- Urethra

ISO 80369-5

- Limb Cuff Inflation
- Tourniquets and BP Cuffs

ISO 80369-6

- Neuraxial
- Spine

ISO 80369-7

- Intravenous
- Arteries and Veins
- The Luer



Short History of the Luer



Image from: Brown, J The Life and Death of the Luer, MD&DI Online

- Hermann Wulfing-Lüer first manufactured the luer syringe in 1894, 130 years ago
- Invented by Karl Schneider....????? Or Jeanne Luer
- The simple design went on to be an effective connector for a wide variety of medical applications
- In 1925 Fairleigh S. Dickinson filed a US patent for a modification that would come to be known as the LUER-LOK

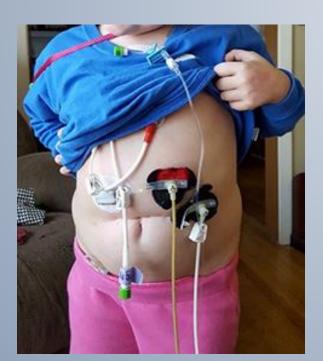






What is a tubing misconnection?

"Tubing, catheter and syringes are a fundamental aspect of daily health provision for the delivery of medications and fluids to patients. The design of these devices is such that it is possible to inadvertently connect the wrong syringes and tubing and then deliver medication or fluids through an unintended and therefore wrong route. This is due to the multiple devices used for different routes of administration being able to connect to each other"







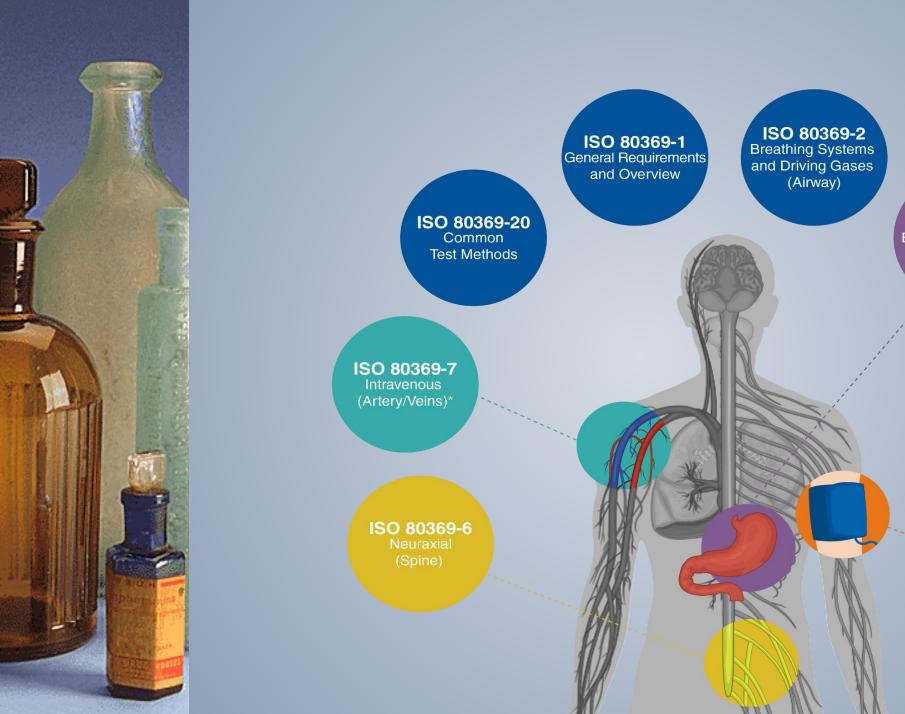
<u>In Their Own Words – YouTube</u>

From stayconnected.org



Examples of Medical Device Misconnections | FDA

- > An anesthetist and a mid wife mistakenly connected an epidural set to a patient's IV tubing as a result epidural medicine was delivered to the IV causing patient death.
- > A child in a pediatric ICU had both an IV line and a trach tube. The IV tubing was mistakenly connected to the trach cuff port. The IV fluid over-expanded the trach cuff to the point of breaking and continuous IV fluids entered the child's lungs resulting in the child death.
- A patient was found with her Foley catheter disconnected from its drainage bag. One end of the catheter was still in her bladder and the other end was connected to her nasogastric (NG) tube. Urine was noted to be flowing into her NG tube. The NG tube was connected to suction and more than 300 mL of urine drained. The patient's vital signs were stable, and her laboratory results were within normal limits



ISO 80369-3 Enteral and Gastric (Stomach)

> ISO 80369-4 Urinary Collection (Urethra)

postponed

ISO 80369-5 Limb Cuff Inflation (Tourniquets and BP Cuffs)





In 2023 Alberta Health Services took the initiative to transition over and meet the global standard changing our supply of enteral feeding products and accessories to be ENfit compliant!

FIGURE 2

Comparison of Syringe Tips⁶

ENFit syringes less than 5 mL were redesigned with a low-dose tip and paired with new dispensing adaptors, like transfer straws, to increase dosing accuracy and avoid inadvertent overdosing due to drug accumulation in the "moat" at the syringe tip.



Image courtesy of the Global Enteral Device Supplier Association (GEDSA) (http://stayconnected.org/wp-content/uploads/2019/03/GEDSA-White-Paper-2019.pdf.)



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What year was the first glass luer syringe manufactured in Paris, France?



How many parts in total does ISO 80369 include?



In 1988 a massive disaster triggered investigations that eventually led to the development of ISO 80369. At what airbase did the disaster occur?



What bodily system is part 6 of the standard associated with?



Wiepking F, Van Zundert A, Martin JP, Cazalaà JB, Buttner R. The all-glass Lüer syringe: Historical facts around concepts, introduction and patents. Anaesth Crit Care Pain Med. 2021 Aug;40(4):100921. doi: 10.1016/j.accpm.2021.100921. Epub 2021 Jun 28. PMID: 34197975. The all-glass Lüer syringe: Historical facts around concepts, introduction and patents - PubMed (nih.gov)

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Milamed, Debra, Karen Brown, Edward Murphy. "Lüer's Lure: From an International Standards Perspective." Anesthesiology 117, no. 6 (2012): 1358-1363. DOI: 10.1097/aln.0b013e318275e78f

Stay Connected Initiative by GEDSA https://stayconnected.org

Gedsa Worldwide, In Their Own Words, June 16, 2020 Video found at: <u>In Their Own Words – YouTube</u>

World Health Organization, "Avoiding Catheter and Tubing Mis-Connections", Patient Safety Solutions, volume 1, solution 7, May 2007. ps-solution7-avoiding-catheter-and-tubing-miss-connections.pdf (who.int)

US Food Drug Administration, Examples of Medical Device Misconnections, 02/23/2023. <u>Examples of Medical Device Misconnections | FDA</u>

Health Canada, Tubing misconnection errors and the anticipated redesign of small bore (Luer) connectors, 2015. Health Product InfoWatch - March 2015 - Canada.ca



Questions?

