LUER MISCONNECTIONS RESULTING IN ADVERSE EVENTS

According to the Centers for Medicare & Medicaid Services ("CMS"), since 1972, there have been in excess of 100 reports of Luer misconnections that have resulted in adverse events. Recently, a patient's blood pressure tubing was misconnected to an intravenous line in an ambulatory surgical center ("ASC") that resulted in the patient's death. Generally, the patients most often affected with the misuse of Luer connectors are those with multiple tubing. However, the aforementioned incident involved a patient undergoing carpal tunnel surgery in an ASC.

As a result of these incidents, The Joint Commission, the FDA and several other associations with interests in promoting safe medical practices and reducing medical errors have received numerous reports of misconnection errors. In response to these reports, the FDA and the medical device community are undertaking steps to reduce tubing misconnections. The FDA encourages health care providers to visit the FDA Tubing and Luer Misconnections website for additional information to decrease the occurrence of these errors. This information should be incorporated into a facility's Quality Assessment and Performance Improvement Program and other educational programs to prevent and/or reduce misconnections.

CMS suggests that surveyors ask facility personnel how they prevent misconnection and encourage facilities to report problems involving Luer misconnections to the FDA even when no adverse event occurs. For additional information, click here.

If you have questions or concerns regarding the foregoing or would like additional information, please contact Todd Selby at tselby@hallrender.com or 317.977.1440, Brian Jent at bjent@hallrender.com or 317.977.1402, David Bufford at dbufford@hallrender.com or 502.568.9368 or your regular Hall Render attorney.