Joe DiMaggio Children's Hospital

Clinical Ladder Presentation

"I'M SO SORRY"
A CASE OF JUST CULTURE?

October 5, 2022

Jennifer Blackman, MSN, RN IV, CPN
C.J. Martinez, RN IV, CPN, CCRN

Objectives

- Upon completion of this presentation, the learner will:
  - Engage and review a case study of criminal charges after medication error
  - Review importance of reporting near misses with regards to patient safety and quality
  - Describe actions by nurses to sustain a culture of safety when administering medications
  - Discuss the meaning of Just Culture as it relates to our healthcare system

JUNE 2022
LETTER FROM
PRESIDENT

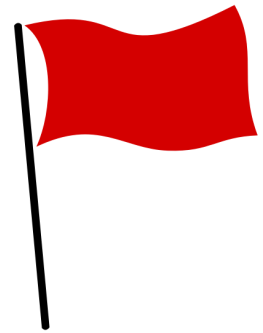
SOCIETY OF PEDIATRIC NURSES

President-Elect
Kathleen Van Allen, MSN, RN, CPN

- "Deeply troubled by recent tragic events that impact our profession"
- "Nurse convicted for criminally negligent homicide"
- "Med error that resulted in death of her patient"
- "Reflect individually and professionally"
- "Move forward with greater clarity and confidence around our practice"

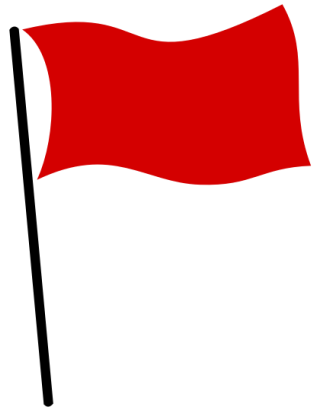
Timeline

- 75 yr. old female CM admitted VUMC 12/24/2017
- CT shows subdural hematoma
- Hx Afib, breast cancer, Guillain-Barre Syndrome, lupus, neuropathy, seizures, anxiety
- Patient ready to be discharged home
- 12/26/17 Scheduled for PET scan
- Pt requested a medication for anxiety prior to going into PET scan
- Patient's nurse (RN 2) asked "All help nurse" (float nurse) RN 1 if she could go to PET scan to administer Versed to patient.
- RN 1 was on the way to another department to assist with a swallow study
- RN1 also had an orientee that day
- Nurse 1 attempted to obtain Versed from the ADC
- Versed not on profile



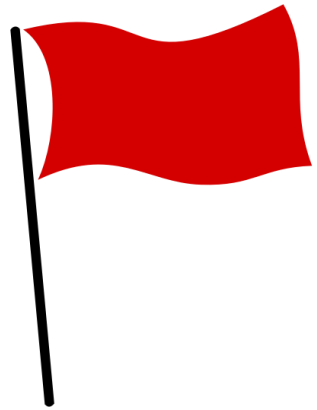
Timeline

- Nurse 1 entered letters "VE" via override.
- Nurse 1 chose first drug that appeared.
- Medication was Vecuronium
- Vecuronium was reconstituted by Nurse 1
- She did not recheck the name on the vial or note the warning signs on the vial.
- Placed reconstituted Vec, saline slushed and alcohol pads in baggie.
- While preparing med, Nurse 1 says was explaining what a swallow study to orientee.
- Went to PET scan, identified patient and administered medication.
- Nurse 1 went to assist in ER with the swallow study.
- No bar code scanner in radiology to scan med prior to administration.
- Patient was placed in radiology holding area to await scan.
- Transporter passing by radiology holding area, and noticed patient appeared unresponsive. (30 min after med administered)



Timeline

- Rapid Response/Blue alert was called
- CPR started-intubated-ROSC
- Returned to Neuro ICU
- Nurse 2 showed Nurse 1 the bag of medication she administered
- Nurse 1 and Nurse 2 realized that Vecuronium was given and not Versed
- Reported this to patient's ARNP, who said " I'm so sorry"
- Nurse 1 completed incident report
- Patient condition deteriorated
- Family consented to withdraw care
- Condition declined and on 12/27/17 patient pronounced dead
- Initial medical examiner cause of death- "natural causes"
- Vecuronium administration not documented in medical record
- Vecuronium administration not communicated to medical examiner
- Incident not reported to state or federal officials as a SENTINEL EVENT



Timeline

- January 2018: Nurse 1 returned to work at VUMC and is terminated
- Early 2018: Vanderbilt negotiates out of court settlement with deceased patient's family
- Settlement requires no communication about death or med error
- May 2018: RaDonda begins working as a "Coordinator" in a Nashville medical center (Not a clinical position but does require a nursing license)
- October 2018: VUMC reports Vaught to DOH for medical error. Tennessee DOH decides not to pursue disciplinary action against Vaught
- October 2018: Anonymous complaint to CMS regarding medical error.

Letter to Vanderbilt University Medical Center from Tennessee Department Of Health regarding a complaint filed against Ms. Vaught

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF INVESTIGATIONS
Metro Center
665 Mainstream Drive, Second Floor
Nashville, TN 37243

615-741-8485 or 1-800-852-2187
www.Tennessee.gov/health

Antoinette.Welch#@Tn.gov

October 23, 2018

Vanderbilt University Medical Center
Attn: Marilyn Dubree
1161 21st Ave S D-3300MCN
Nashville, TN 37232

Re: Report Filed Against - RADONDA VAUGHT, RN

Dear Ms. Dubree,

Thank you for the opportunity to review your concerns. Your complaint against the above-named practitioner was received, and a complaint file was opened. The complaint file was reviewed by the Board's consultant, a licensed member of that profession, and a staff attorney for the Department of Health. As a result of the review, the file was forwarded to the field for investigation.

An investigation was conducted, and the results of the investigation were returned to this Office. The results of the investigation were reviewed by the Board's consultant, together with a staff attorney for the Department of Health. As a result of this review, it was their determination that the acts of the practitioner did not constitute a violation of the statutes and/or rules governing the profession. Therefore, the complaint has been closed, but the record will remain on file in this Office.

We appreciate your notifying our Office of your concerns and, while the outcome may not have met your expectations, please be assured that a legal assessment was made based on the statutes and rules governing this profession.

Sincerely,

Antoinette Welch, Esq.
Director Office of Investigations
Tennessee Department of Health

AW: bc

Complaint No.: 201800900

Printed: 12/10/2018
Due Date: 10/05/2018
Priority: IJ

INTAKE INFORMATION

Intake Number: TN00045852
Facility ID: TNP53127
Provider Number: 440039
State Region: TNW

PROVIDER INFORMATION:

Name: VANDERBILT UNIVERSITY MEDICAL CENTER
Address: 1211 MEDICAL CENTER DRIVE
City/State/Zip/County: NASHVILLE, TN, 37232, DAVIDSON
Telephone: (615) 322-3454
License #: 53127
Type: HOSP-ACU
Medicaid #:
Administrator: C. WRIGHT PINSON

INTAKE INFORMATION:

Intake Number: TN00045852
Taken by - Staff: (b)(6)
Location Received: STATE AGENCY CENTRAL OFFICE
Intake Type: Complaint
Intake Subtype: Federal COPs, CFCs, RFPs, EMTALA, CLIA
SA Contact: (b)(6), (b)(7)c
RO Contact:
Responsible Team: STATE AGENCY WEST TENNESSEE
Source: Anonymous
Received Start: 10/03/2018 At 10:20
Received End: 10/03/2018 At 10:20
Received by: In Person
State Complaint ID:
CIS Number:
External Control #:

COMPLAINANTS:

Name	Address	Phone	EMail
Not Applicable			

Link ID: (b)(7)d
Confidentiality Requested : Y

INTAKE DETAIL:

Date of Alleged Event: Time: Shift:

Standard Notes: An anonymous complainant reports the following:

On December 26, 2017 (b)(6), (b)(7)c administered an incorrect medication to (b)(6), (b)(7)c , a patient at Vanderbilt University Medical Center when she was awaiting a PET scan.
(b)(6), (b)(7)c was "the help all nurse" for the Neuro Intensive Care Unit, stepdown and the 6th floor nursing units. She was orienting a new registered nurse (b)(6), (b)(7)c The stepdown nurse asks (b)(6), (b)(7)c to give (b)(6), (b)(7)c some versed for anxiety before her PET scan.
(b)(6), (b)(7)c removed the incorrect drug from the Pyxis, did not read the label and accidentally administered vecuronium instead of versed.
(b)(6), (b)(7)c was in the PET scan for 20 minutes. When the patient came out of the PET scan unit, she was unresponsive, was resuscitated and passed away in the Neuro Intensive Care Unit later that day.
During an investigation with Board of Investigations (b)(6), (b)(7)c stated she administered the incorrect medication to (b)(6), (b)(7)c before the patient had the PET scan and she didn't read the label after she pulled the incorrect drug from the Pyxis. She reported the order had not crossed over to the Pyxis and when she typed in Versed, she accidentally picked the first medication that come up on the screen. She was in a busy area without a "no talk zone" designated sign. She further stated, there was no place to scan the medication before giving it to the patient. She gave the medication IV and flushed after.
It is reported the nurse did not check the Dr. orders, follow the 5 rights of medication administration, administered a drug outside her scope of practice, and failed to properly monitor the patient after administering a medication.
The patient suffered an anoxic brain syndrome as a result of being given the vecuronium and died.
(b)(6), (b)(7)c was terminated from VUMC on January 3, 2018.
Vanderbilt University Medical Center did not report this sentinel event via IRS to the SSA.

*****Please see attached Investigative Report from Health Related Boards*****

Extended RO Notes:
Extended CO Notes:

ALLEGATIONS:

Category: Accidents
Sub-category:
Seriousness:
Details:

VMUC Received "Immediate Jeopardy" Letter

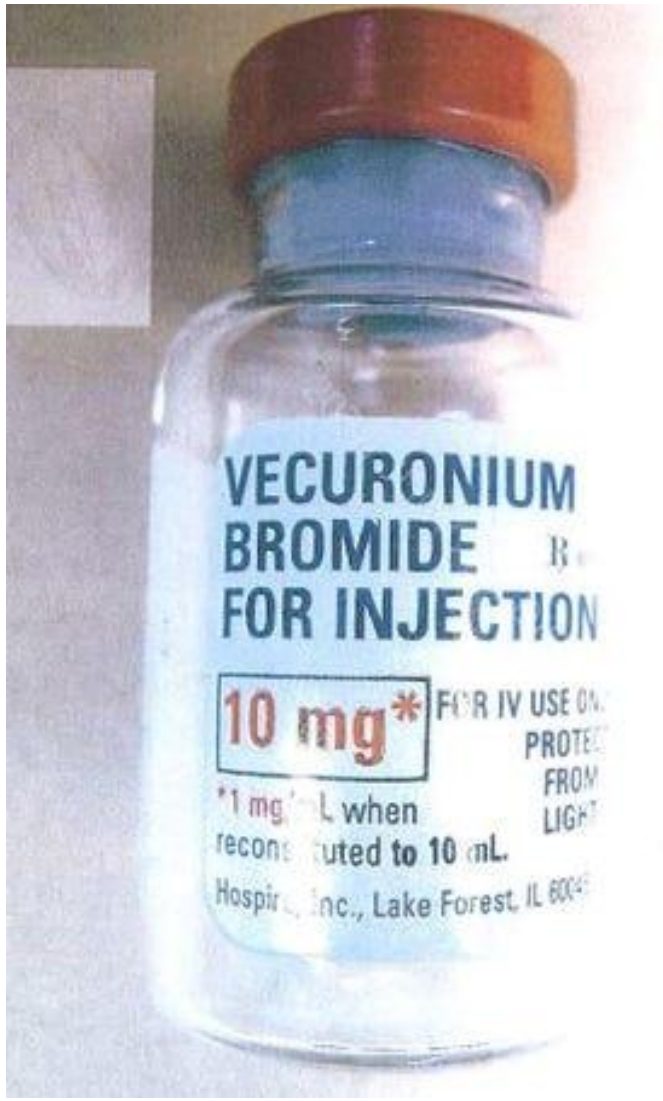
- Complaint survey conducted
- Hospitals must meet "Medicare Conditions of Participation"

- Complaint survey identified an Immediate and serious threat to patient health and safety.
- Effective November 8, 2018, Status by Joint Commission is removed.
- Medicare provider agreement will be terminated on December 9. 2018 if immediate jeopardy is not removed by this date.
- No payments for inpatient hospital services admitted on or after December 10, 2018.

An acceptable plan of correction must contain the following elements:

1) The plan of correcting the specific deficiency cited. The plan should address the processes that lead to the deficiency cited;
2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
4) The title of the person responsible for implementing the acceptable plan of correction.


REF DYND30261
BIOHAZARD
FROZEN
REFRIGERATE
PREP PAD


VECURONIUM
BROMIDE
FOR INJECTION
10 mg*
when
to 10 mL.


WARNING: PARALYZING AGENT

Timeline

- October 31-November 2018: CMS conducts a surprise inspection at VUMC
- Confirms patient died of accidental Vecuronium dose and did not report this to government and medical examiner
- Late November 2018: Circumstances of fatal error becomes public for first time
- November 2018: VUMC submit plan of corrections to HHS and CMS
- Revises policy of transport of patients
- Communication and handoff, documentation of handoff
- Time the patient leaves and returns to unit
- Moderate sedation policy
- By Dec. 3: Training of all clinical leaders, nurses, RRT's, for all inpatient and ambulatory departments:
  - Transport policy, High Alert medications, medication administration policy, monitoring of patients during and after medication administration, handover, MR documentation

Timeline

- After December 3, 2018 (and 3 months thereafter) CNO must conduct 5 chart reviews weekly for compliance for improvement in medication safety, transport, and monitoring of patient.
- Remove Vecuronium from AcuDose
- Shrink wrap all paralytic agents
- "Help ALL Nurse" (resource nurse) role definition
- Reporting incidents to Risk Management
- Event review committee to ensure reporting of events to appropriate federal agencies
- 105-page document from CMS/HHS on VUMC deficiencies and corrective actions

Timeline

- Feb.4, 2019: RaDonda Vaught is arrested on a criminal indictment for her alleged role in CM's death
- Charged with reckless homicide and impaired adult abuse
- Feb 8, 2019: In a GoFundMe post to raise money for her legal defense, Vaught appears to admit she made a mistake but does not elaborate.

Timeline

- **Feb. 20, 2019:** Vaught makes her first appearance in court in her criminal case and enters a not guilty plea to all charges.
- **August 20, 2019:** At the request of law enforcement, Nashville Medical Examiner Feng Li re-examines the circumstances of Murphey's death. Now aware of the medication error, Li changes Murphey's official manner of death to "accidental."
- **Sept. 27, 2019:** The Tennessee Department of Health reverses its prior decision not to pursue professional discipline against Vaught.
- **Late October to mid-November, 2019:** Because Vaught is now facing two legal proceedings, a criminal trial and a professional discipline hearing, a debate begins over which case should proceed first

Timeline

- **May 20-21, 2020:** Vaught's professional discipline hearing is scheduled at a quarterly hearing of the Tennessee Board of Nursing
- **Spring, 2020:** The coronavirus pandemic delays both Vaught's professional discipline hearing and her criminal trial.
- **July 23, 2021:** The Tennessee Board of Nursing revoked Vaught's nursing license. Board members appear sympathetic to her case but do not overlook her errors.
- **March 21, 2022:** Vaught's criminal trial begins.
- **March 25, 2022:** Trial ends with the jury finding Vaught guilty of criminally negligent homicide and abuse of an impaired adult
- **March 2022:** RaDonda Vaught was convicted of criminally negligent homicide for a medical mistake. In May, Vaught was sentenced to three years supervised probation.

The Family

- The son of a woman who was killed by a medication mix-up at Vanderbilt University Medical Center said his mother would forgive the nurse alleged to be responsible for her death and that her family won't pursue legal action against the hospital where she died.
- “I know my mom well, and she would be very upset knowing that this lady may spend some of her life in prison,” Gary Murphey told The Tennessean. “She probably had a family, and it’s destroyed their life too.”

President-Elect
Kathleen Van Allen, MSN, RN, CPN

SOCIETY OF PEDIATRIC NURSES

- Professional responsibility to safely practice nursing
- Challenges of the work environment
- Complexity of work and many demands placed on us
- Lives entrusted to us
- Do not go to work intending to make a mistake or harm
- Errors happen to the most skilled and experienced nurse
- Many feeling from nurses on case: outrage of trial or difficulty to understand the mistake
- We must not be divided-we all bear responsibility to ensure care is delivered safely
- Work collaboratively to address systemic issues such as safe staffing
- Ensuring processes that promote safety and support nurses in providing care

ANA and Institute for Healthcare Improvement Statements after trial:

"While we are relieved that Ms. RaDonda Vaught did not receive a prison sentence, we remain disappointed and deeply concerned about the criminalization of error in medicine, which offers no remedy for improving patient safety. In fact, Ms. Vaught's arrest and conviction makes patients less safe," the IHI said in a statement.

"We are grateful to the judge for demonstrating leniency in the sentencing of Nurse Vaught. Unfortunately, medical errors can and do happen, even among skilled, well-meaning, and vigilant nurses and healthcare professionals," the ANA said in a statement

ISMP
INSTITUTE FOR SAFE MEDICATION PRACTICES

Lack of evidence about the system failures
The error was a culmination of multiple system failures throughout the medication-use process that contributed to Charlene Murphey's death
Access to a neuromuscular blocking agent via override in an automated dispensing cabinet (ADC) after entering just the first two letters of a drug's name
Unsafe ADC storage of a neuromuscular blocking agent outside of a sealed box or rapid sequence intubation (RSI) kit
Allowing medications to be ordered by a brand name, Versed, that has long been discontinued (2003)
Lack of barcode technology in the radiology unit
There was no discussion (and likely no jury understanding) about the latent failures that allowed this error to happen—only the active failures of one nurse, RaDonda.

ISMP
INSTITUTE FOR SAFE MEDICATION PRACTICES

The event should have been prevented. In 2016, a full year before RaDonda's fateful error, ISMP published a feature article about errors with neuromuscular blocking agents

In 2016, ISMP released a ***Targeted Medication Safety Best Practice for Hospitals*** that aims to promote safe storage of neuromuscular blocking agents

Healthcare Organizations tend to turn a blind eye to both risky systems and risky choices "Patients are safe if bad outcomes or errors do not happen to them

Unfairness of the Trial and the Guilty Verdict

Offensive attribution of RaDonda's behavior as "driving drunk" and "driving with her eyes closed.

Creating a Culture of Safety as Nurses and Nurse Leaders

Administering medication safely requires five "rights":
The right patient
The right medication
The right time
The right dose
The right route

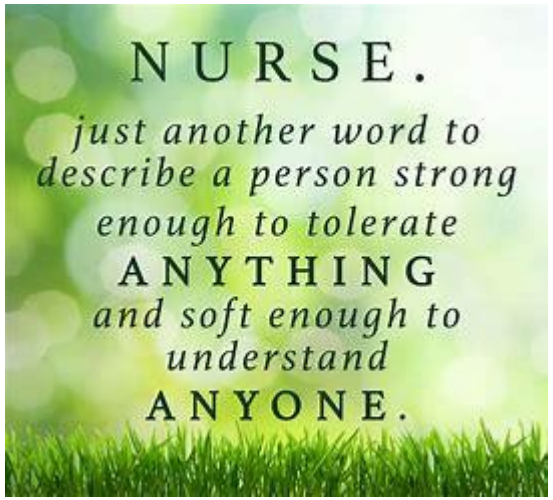
1. If You See Something, Say Something
2. Understand Your Limits
3. Report Issues With Systems That Require Overrides
4. Pay Attention to Alerts and Alarms

What Nurse Leaders Can Do

Beyond nurses, nurse leaders and hospitals have a role in protecting nurses and creating a culture of safety. Protecting nurses fosters a culture of safety that protects patients.

Nursing leaders and healthcare institutions have the responsibility to create, measure, and reevaluate the systems that are in place to protect the nurse as well as the patient.

1. Advocate for Their Staff
2. Create an Environment of Accountability
3. Ensure Proper Staffing Ratios
4. Incorporating Rounds and Debriefs as Daily Practices
5. Encourage Writing and Reporting Incident Reports
6. Constantly Look for Ways to Improve Safety
7. Build Multidisciplinary Collaborations



Joe DiMaggio Children's Hospital

Just Culture

Just Culture

- Emphasizes quality and safety over blame and punishment
- Promotes a process where mistakes do not result in automatic punishment but rather a process to uncover the root of the error
- Human error that are not deliberate result in coaching, counseling, and/or education to decrease the likelihood of a repeated error
- Promotes error reporting that leads to system improvements to create safer environments for patients and staff

Just Culture: The Background

1.

Just Culture™ Case Review

Facility:_____ **Date:**_____

Incident Summary

What happened?

Insert overview of incident, parties involved and outcome, including the date the incident occurred

Just Culture: The Background

2. **Investigation Findings**

What Should Have Happened? *(What is the Procedure?)*

State what is expected to happen, i.e. Policy and procedures that pertain to the incident and expected process.

What Normally Happens? *(Department Norms)*

State how similar incidents are handled in the department. Are there "short cuts" that seem to be acceptable (i.e. everyone does it). How is the process normally done within this department or division?

Why Did it Happen? *(Potential Contributing Factors)*

Explain any extenuating circumstances: distractions, stress level, experience of staff, conflicting values, etc. Include employee's response when asked to explain their behavior/choice.

What Role Did the Organization Play? *(i.e., process issues, equipment failure, lack of support from management)*

Describe the organization/system role in the issue, if applicable. What Breaches Occurred?

Just Culture: The Background

3. Review all questions on the appropriate algorithm and list rationale for algorithm outcomes

Duty to Produce an Outcome

Duty to Follow a Procedural Rule

Duty to Avoid Causing Unjustifiable Risk or Harm

Repetitive Human Error

Repetitive At-Risk Behavior

Human Error	At-Risk Behavior	Reckless Behavior
Product of Our Current System Design and Behavioral Choices	*A Choice: Risk Believed Insignificant or Justified*	*Conscious Disregard of Substantial and Unjustifiable Risk*
Manage through changes in: • Choices • Processes • Procedures • Training • Design • Environment	Manage through: • Removing incentives for at-risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness	Manage through: • Remedial action • Punitive action
Console	**Coach**	**Punish**

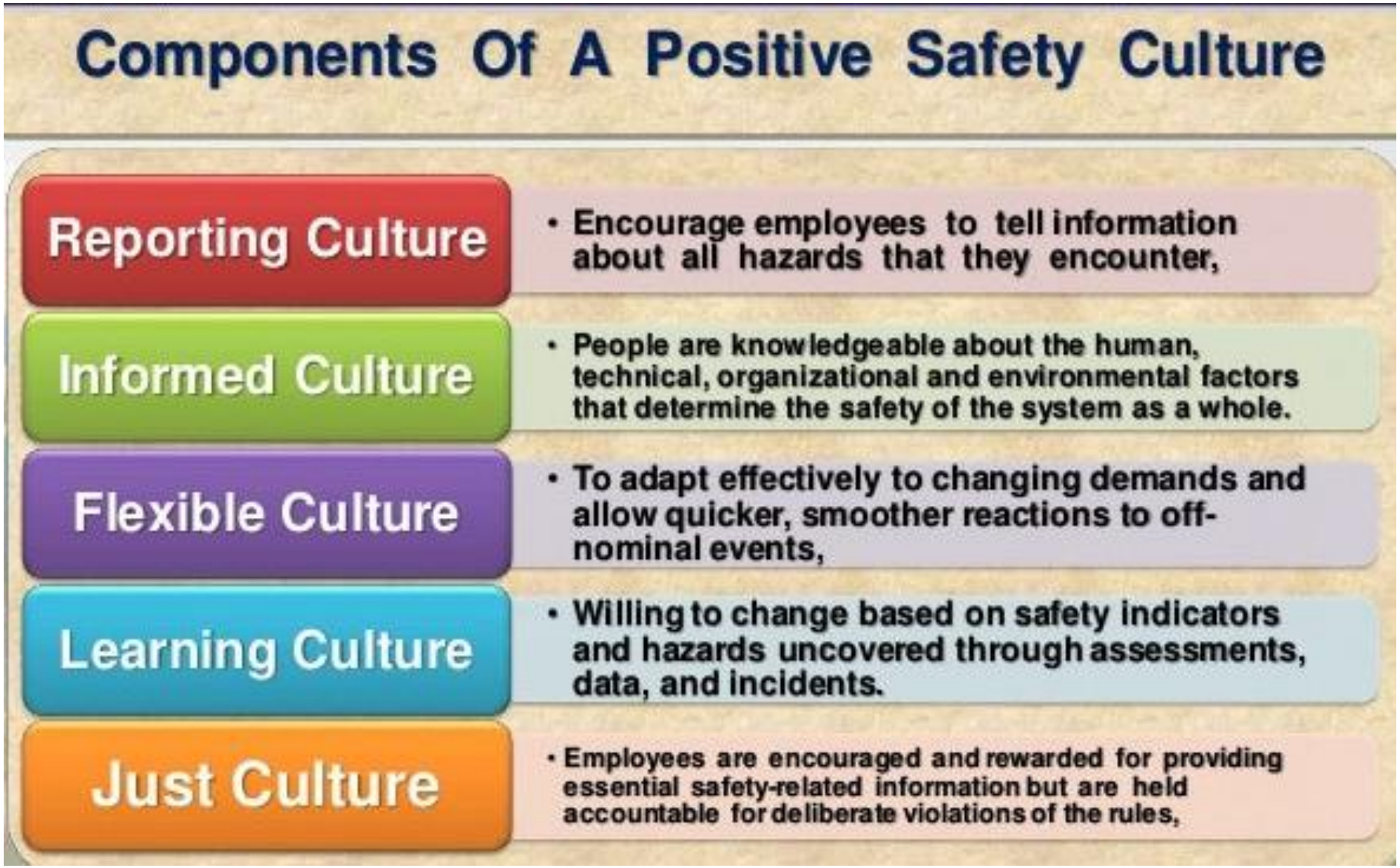
Just Culture: The Background

4. **Actions Taken**

How is the Organization Managing Future Risk?

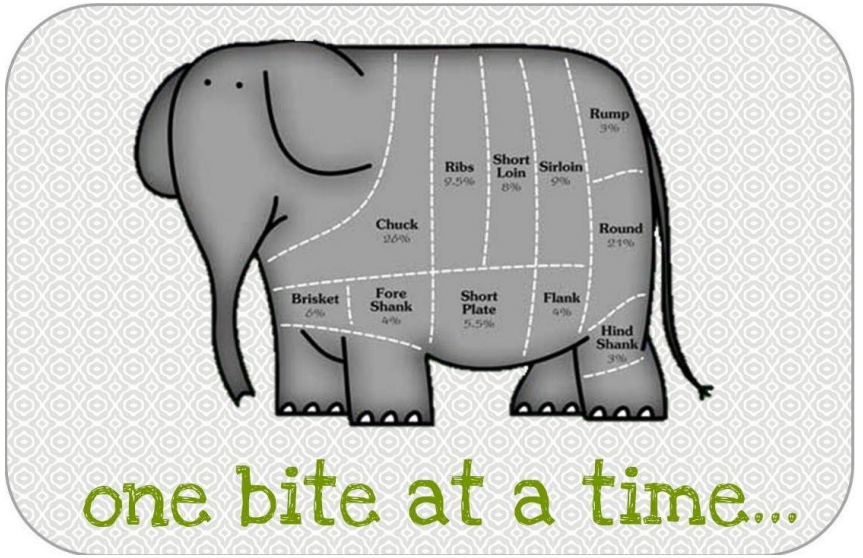
What will we do differently as a result of this incident?

How will we communicate what we are doing?


Components Of A Positive Safety Culture
Reporting Culture
• Encourage employees to tell information about all hazards that they encounter,
Informed Culture
• People are knowledgeable about the human, technical, organizational and environmental factors that determine the safety of the system as a whole.
Flexible Culture
• To adapt effectively to changing demands and allow quicker, smoother reactions to off-nominal events,
Learning Culture
• Willing to change based on safety indicators and hazards uncovered through assessments, data, and incidents.
Just Culture
• Employees are encouraged and rewarded for providing essential safety-related information but are held accountable for deliberate violations of the rules,

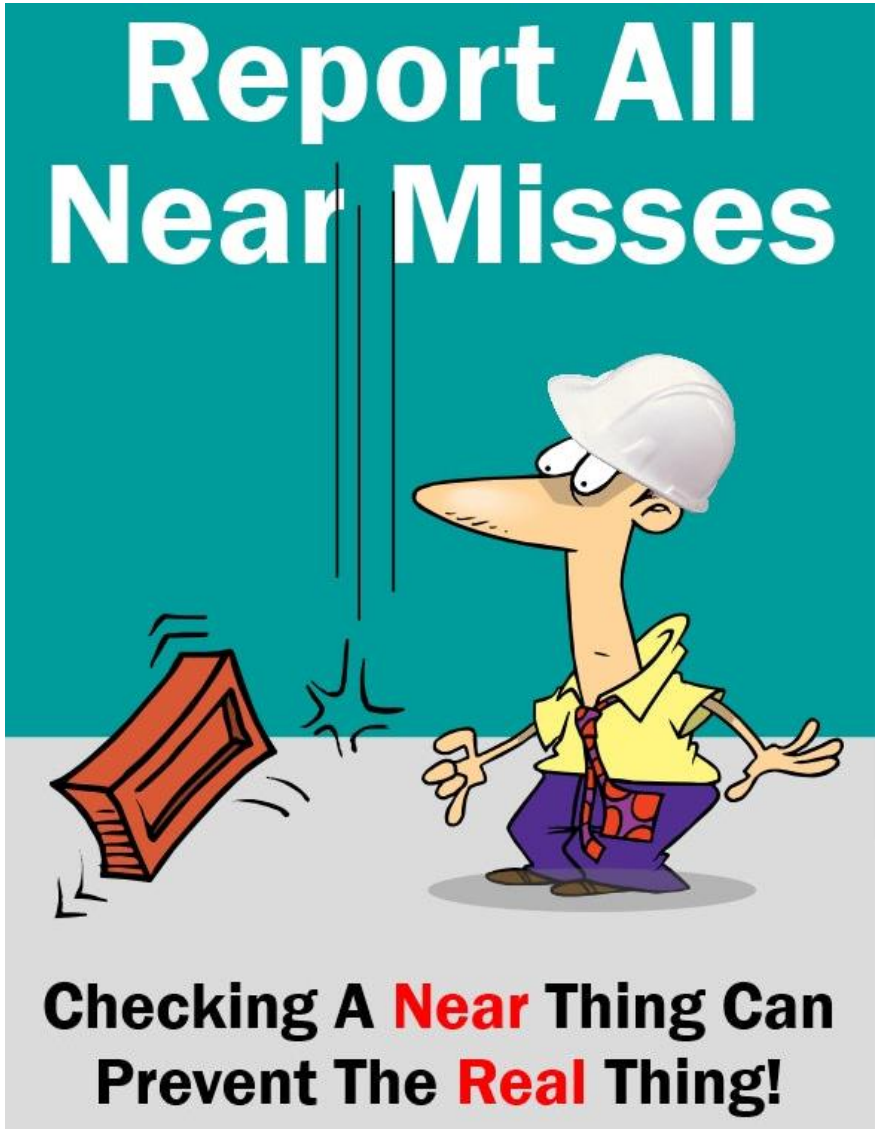
What YOU Can Do:

Reporting	• A culture where people are prepared to report errors and near misses
Risk Aware	• Risk and controls are known
Learning	• We learn from mistakes-good and bad news travels fast
Informed	• Managers and Operators are aware of all issues that impact operational safety
Just	• Safety matters are treated fairly and equitably



Incident Reporting

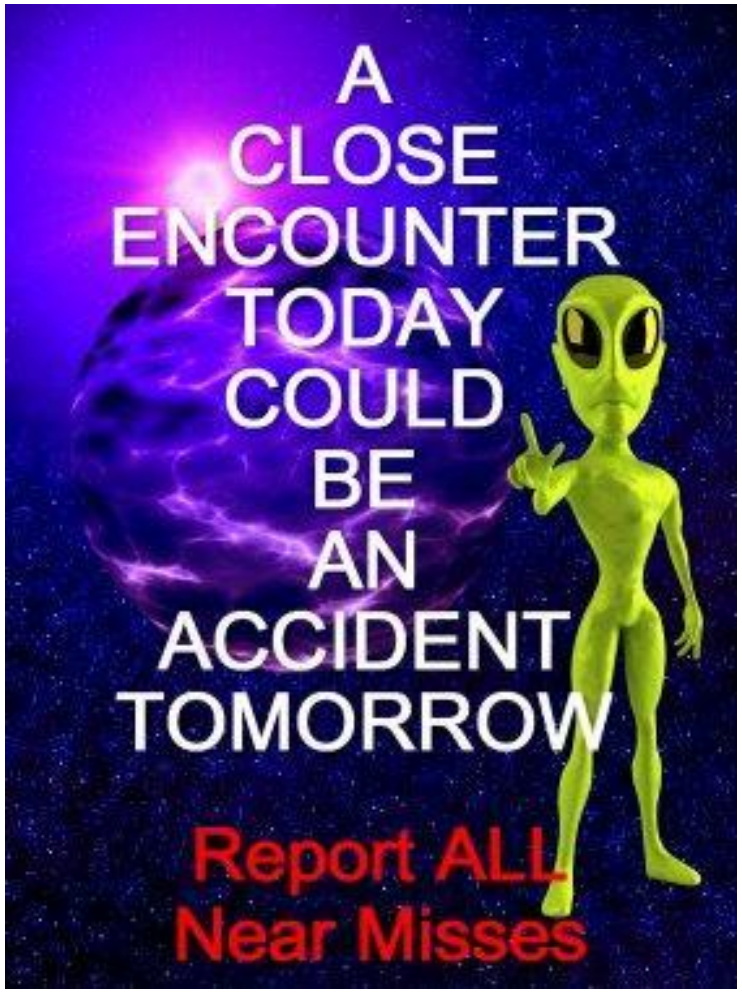
According to the MHS standard of practice, an incident is defined as “any deviation from routine operation of the hospital, including, without limitation, injury, hazard, unexpected complication or adverse result, near-miss, allegations of sexual misconduct, or death while in or related to seclusion or restraints” (Memorial Healthcare System, 2015)
The goal of incident reporting is to identify patterns or trends at JDCH or throughout the MHS



Incident Reporting

The overall goal is to improve patient safety! Incident reports:

- are not a punitive process, they are meant to improve our processes
- can identify areas in the system that may increase risk of an incident occurring
- alert the Risk Manager to review incidents and identify risk for potential claim
- share lessons across a healthcare system
- identify system designs or areas of opportunities to decrease risk for safety or harm
- identify patterns or trends at JDCH and/or throughout the MHS
- compile experiences for uncommon problems
- are required by Florida Law!



References

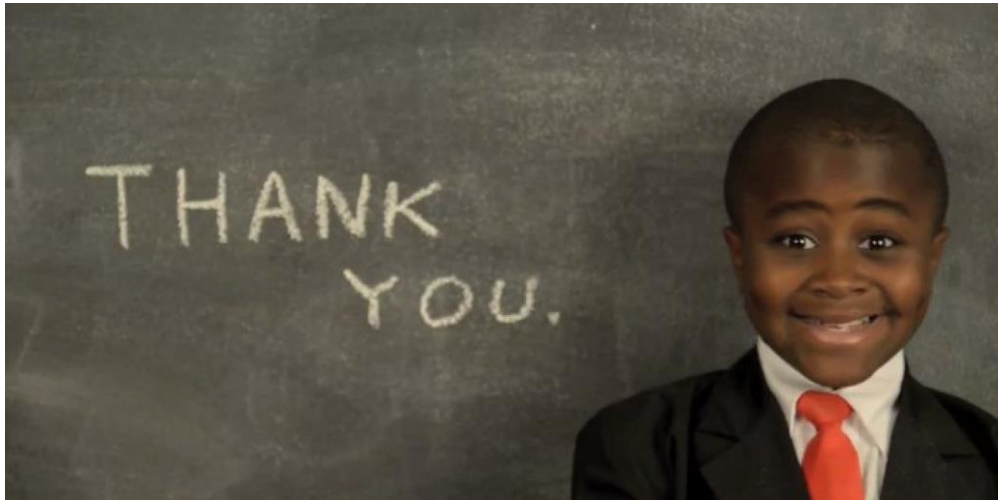
- www.outcome-eng.com, Copyright 2004, 2019 Outcome Engenuity, LLC
- Centers For Medicare & Medicaid Services (CMS). (2018). Statement of Deficiencies and Plan Of Correction. https://www.documentcloud.org/documents/6535181-Vanderbilt-Corrective-Plan.html
- Centers For Medicare & Medicaid Services (CMS). (Oct 3, 2018) Anonymous Complaint https://www.documentcloud.org/documents/6542003-CMS-Complaint-Intake.html
- Department of Health and Human Services. (2018). Statement of Deficiencies – Vanderbilt University Medical Center. November 8, 2018. https://www.documentcloud.org/documents/6535181-Vanderbilt-Corrective-Plan.html
- Institute for Safe Medication Practices (ISMP). Criminalization of Human Error and a Guilty Verdict: A Travesty of Justice that Threatens Patient Safety | https://www.ismp.org/resources/criminalization-human-error-and-guilty-verdict-travesty-justice-threatens-patient-safety

References

- Feeney, A. (2022). Update: RaDonda Vaught Sentenced to 3 Years Supervised Probation. https://nursejournal.org/articles/radonda-vaught-medical-errors-what-nurses-can-do/
- Kelman, B. (2022). The RaDonda Vaught trial has ended. This timeline will help with the confusing case. Nashville Tennessean, March 27, 2022. https://www.tennessean.com/story/news/health/2020/03/03/vanderbilt-nurse-radonda-vaught-arrested-reckless-homicide-vecuronium-error/4826562002/
- Kelman, B. (2022). In Nurse's Trial, Investigator Says Hospital Bears 'Heavy' Responsibility for Patient Death. KHN, March 24, 2022. https://khn.org/news/article/radonda-vaught-fatal-drug-error-vanderbilt-hospital-responsibility
- DEPARTMENT OF HEALTH AND HUMAN SERVICES/CENTERS FOR MEDICARE AND MEDICAID SERVICES, Immediate Jeopardy Letter 11/16/18, https://www.modernhealthcare.com/assets/pdf/CH1180721128.PDF

Please provide feedback!

Scan QR Code:




abc NEWS EXCLUSIVE
GMA

Thank You.

Joe DiMaggio Children's Hospital

BEST CHILDREN'S HOSPITALS U.S.News & WORLD REPORT CARDIOLOGY & HEART SURGERY 2021-22

BEST CHILDREN'S HOSPITALS U.S.News & WORLD REPORT ORTHOPEDICS 2021-22

PLANETREE DESIGNATED

954-265-5324 | JDCH.com

BOCA RATON | CORAL SPRINGS | HOLLYWOOD | MIRAMAR
PEMBROKE PINES | WELLINGTON | WESTON