Patient and Public Accountability for Error and Harm: The Vanderbilt Nurse Case Revisited

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Disclaimers

- My thoughts on the Vanderbilt case are based on media coverage, publicly available documents, and conversations with other experts in patient safety and "just culture"
- I have not immersed myself in the details of the legal proceedings beyond basic accounts
- I have no confidential or insider information

Vanderbilt Case Timeline

	Description
December 26, 2017	Overriding alerts from the automated drug dispenser, nurse RaDonda Vaught administers IV vecuronium instead of Versed (midazolam) to patient Charlene Murphey in connection with an inpatient diagnostic procedure.
December 27, 2017	Patient suffers prolonged cardiorespiratory arrest in a PET scanner; she later is withdrawn from life support and dies.
January 3, 2018	Hospital fires nurse for not following the "five rights" of medication administration (patient, drug, dose, route, time).
January 2018	Hospital settles with patient's family, requiring them to not speak about the error publicly.

Brett Kelman, *The RaDonda Vaught Trial Has Ended. This Timeline Will Help With the Confusing Case.*, The Tennessean (Mar. 27, 2022), https://www.tennessean.com/story/news/health/2020/03/03/vanderbilt-nurse-radonda-vaught-arrested-reckless-homicide-vecuronium-error/4826562002/ [https://perma.cc/YL86-E8A9].

Vanderbilt Case Timeline

October 3, 2018	Anonymous whistleblower alerts state/federal agencies about the fatal error.
October 23, 2018	TN Department of Health (Nursing Board) decides not to pursue disciplinary action against the nurse and sends the hospital and nurse a letter affirming its decision.
October/November 2018	In response to the whistleblower, CMS conducts a surprise hospital inspection.
November 2018	CMS releases details of the error, and the hospital submits a plan of correction. (CMS's limited actions remain under appeal to OIG).
February 4, 2019	Nurse charged with criminal reckless homicide and impaired adult abuse.
March 27, 2019	State investigators allege nurse made 10 separate errors, including overlooking warning signs.
September 27, 2019	TN Department of Health (Nursing Board) reverses its prior decision to not pursue discipline against the nurse and charges her with unprofessional conduct, abandoning/neglecting a patient, and failing to document the error.
May 20-21, 2020	Nurse's disciplinary hearing is scheduled but delayed due to the pandemic.
July 13, 2020	Nurse's criminal trial is scheduled but delayed due to the pandemic.
July 22-23, 2021	• Nurse's disciplinary licensing hearing is held. • Board revokes the nurse's professional license and fines her $3,000.
March 25, 2022	After a short trial, a jury convicts Vaught of gross neglect of an impaired adult and negligent homicide (maximum sentence of eight years in prison). On May 13, 2022, Judge Jennifer Smith sentences Vaught to three years' probation

Statement of American Nurses Ass'n and TN Nurses Ass'n

- "We are deeply distressed by this verdict and the harmful ramifications of criminalizing the honest reporting of mistakes.
- Health care delivery is highly complex. It is inevitable that mistakes will happen, and systems will fail. It is completely unrealistic to think otherwise. The criminalization of medical errors is unnerving, and this verdict sets into motion a dangerous precedent. There are more effective and just mechanisms to examine errors, establish system improvements and take corrective action. The non-intentional acts of Individual nurses like RaDonda Vaught should not be criminalized to ensure patient safety.
- The nursing profession is already extremely short-staffed, strained and facing immense pressure – an unfortunate multi-year trend that was further exacerbated by the effects of the pandemic. This ruling will have a long-lasting negative impact on the profession.

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Statement of American Hospital Ass'n

- The verdict in this tragic case will have a chilling effect on the culture of safety in health care. The Institute of Medicine's landmark report To Err Is Human concluded that we cannot punish our way to safer medical practices. We must instead encourage nurses and physicians to report errors so we can identify strategies to make sure they don't happen again. Criminal prosecutions for unintentional acts are the wrong approach. They discourage health caregivers from coming forward with their mistakes, and will complicate efforts to retain and recruit more people in to nursing and other health care professions that are already understaffed and strained by years of caring for patients during the pandemic.

- [After sentencing]: We are pleased that the judge showed leniency in the sentencing of a health care professional who made a medical error. Tragic incidents that result from medical errors should not be criminalized. When errors happen hospitals and health systems need open lines of communication to identify and understand the series of events so they can update patient safety systems to further prevent errors. Criminal prosecutions will discourage health caregivers from coming forward with their mistakes and will complicate efforts to retain and recruit more people into nursing and other health care professions that are already understaffed.

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