Nurses: Caregivers Not Criminals

Dr. Marilyn L. Dollinger RN

President ANA-NY

Hon. Richard A. Dollinger (Ret.)

AMERICAN NURSES ASSOCIATION NEW YORK

Learning Outcomes

- Nurses will study the RaDonda Vaught RN case to understand the dangerous trend of malpractice being prosecuted as a criminal offence and how it may impact health care providers' future professional practice.
- Nurses will be prepared to minimize harm to their careers by understanding the reasons to have their own malpractice insurance and situations when they need representation by legal counsel.

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Objectives

- Review the malpractice case and resulting criminal conviction of RaDonda Vaught RN: event, timeline and outcome.
- Analyze the four elements of malpractice and apply them to the RaDonda Vaught case.
- Analyze the difference in outcomes when using the best practice “Just Culture” Framework for dealing with professional errors.
- Articulate the reasons for all RN/APRNs to have individual malpractice insurance.
- Discuss the necessity of legal counsel during any part of an investigation of professional practice.

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Timeline

- Dec. 26, 2017: **Medication error and patient death next day**
  - Death reported as “natural” from brain bleeding
  - **RN Vaught fired January 2018**
- Early 2018: Hospital civil settlement with patient’s family with non-disclosure clause
- May 2018: Vaught works in non-clinical coordinator position in Nashville hospital
- Oct. 3, 2018: Hospital whistleblower report to state and federal health officials
- **Oct. 23, 2018:Tennessee Board of Health hearing for Nurse Vaught**
  - **The case “did not constitute a violation …did not merit further action”**
- https://www.tennessean.com/story/news/health/2020/03/03/vanderbilt-nurse-radonda-vaught-arrested-reckless-homicide-vecuronium-error/4826562002/

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Timeline

- Oct. 31-Nov. 8, 2018: **Surprise CMS inspection**
  - Confirms cause of death from accidental overdose of vercuronium
  - Threatens suspension of Medicare payments
- Late Nov. 2018: Vanderbilt Plan of Correction for CMS accepted
- **Feb. 4, 2019: Vaught arrested on criminal indictment**
  - **Reckless homicide and impaired adult abuse**
- Feb. 5, 2019: **TN Board of Licensing Health Care Facilities meeting takes no disciplinary action against Vanderbilt**
  - Vanderbilt CEO admits failure to report death
  - Hospital's response was too limited
  - Settlement done with patient's family

https://www.tennessean.com/story/news/health/2020/03/03/vanderbilt-nurse-radonda-vaught-arrested-reckless-homicide-vecuronium-error/4826562002/

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Timeline

- Aug. 20, 2019: Patient's cause of death changed to "accidental" by medical examiner
- **Sept. 27, 2019: Second Tennessee Board of Health hearing reversed prior decision**
  - **Charged with unprofessional conduct, abandoning a patient and failing to maintain an accurate record**
- Oct./Nov. 2019: Facing criminal trial and professional discipline hearing
  - Both delayed by pandemic
- **Dec.15, 2019: *Tennessean* story on Vanderbilt's handling of the incident**
  - **Grandson calls it a "cover-up"**
- **July 23, 2021: TN Board of Nursing revokes Vaught's RN license**
- **Mar. 21-25, 2022: Criminal trial with guilty verdict**
  - **Criminally negligent homicide and abuse of impaired adult**

https://www.tennessean.com/story/news/health/2020/03/03/vanderbilt-nurse-radonda-vaught-arrested-reckless-homicide-vecuronium-error/4826562002

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Timeline

- May 13, 2022: **Sentenced with judicial diversion**
  - No jail
  - 3 years probation
  - Conviction can be expunged after parole completed
- Kaiser Health Network reports: State investigators found Vanderbilt University Medical Center had a “heavy burden of responsibility” for a grievous drug error that killed a patient in 2017, but pursued penalties and criminal charges only against the nurse and not the hospital itself.

https://khn.org/news/article/radonda-vaught-fatal-drug-error-vanderbilt-hospital-responsibility/

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Malpractice

- Malpractice is negligence by a **professional**
- 4 elements of negligence
  - Duty
  - Breach of Duty
  - Proximate Cause
  - Harm/Damages
- ALL 4 elements must be present…otherwise NO Malpractice
- Malpractice by its DEFINITION is an **unintentional** tort

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Standard of Care

- Healthcare Professionals' Standard of Care: Best practices based on evidence-based protocols

- Legal Standard of Care: What would a reasonably prudent person with similar education and experience do in the same situation

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Apply the Elements of Malpractice

- Duty
- Breach of Duty
- Proximate Cause
- Harm/Damages

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Civil Action v. Criminal Conviction

- If you are found liable in a civil action
  - Burden of proof: *Preponderance of the evidence*
  - The result is you pay money—you do not go to jail

- If you are found guilty in a criminal case
  - Burden of proof: *Guilty beyond a reasonable doubt*
  - The result is you are punished by going to jail or probation or fines.

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Criminal Charges, Convictions and Sentencing

- **Sentencing: Eligible for diversion program on both counts**
- **Charged** with reckless homicide
  - Assumption that the RN saw the risk but disregarded the "substantial and unjustifiable risk of harm to the patient" which resulted in death
- **Convicted** on criminally negligent homicide
  - Jury found that the RN failed to see a substantial and unjustifiable risk that should have been seen

https://www.tennessean.com/story/news/crime/2022/05/13/radonda-vaught-sentenced-vanderbilt-nurse/9717529002/

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Criminal Charges

- **Charged and convicted** of abuse of an impaired adult: TN Code § 71-6-119 (2018)

  (a) It is an offense to knowingly, other than by accidental means, physically abuse or grossly neglect an impaired adult if the abuse or neglect results in serious mental or physical harm.

  (b) In order to prosecute and convict a person for a violation of this section, it is not necessary for the state to prove the adult sustained serious bodily injury as required by § 39-13-102, but only that the elements set out in subsection (a) occurred.

  (c) A violation of this section is a Class C felony.

https://law.justia.com/codes/tennessee/2018/title-71/chapter-6/part-1/section-71-6-119/#:~:text=(a)%20It%20is%20an%20offense,serious%20mental%20or%20physical%20harm.

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Advocacy from the Professions

ANA and TNA Joint Statement

Mar 25th 2022

- **SILVER SPRING, MD-**Today, a jury convicted former Vanderbilt University Medical Center nurse RaDonda Vaught of criminally negligent homicide and impaired adult abuse after she mistakenly administered the wrong medication that killed a patient in 2017. The following statement is attributable to both the American Nurses Association (ANA) and the Tennessee Nurses Association (TNA):
- "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.
- Like many nurses who have been monitoring this case closely, we were hopeful for a different outcome. It is a sad day for all of those who are involved, and the families impacted by this tragedy."

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ANA-NY Statement

- **Albany, NY** - Recent events in Tennessee that resulted in the criminal conviction of Nurse RaDonda Vaught, should raise serious questions for nurses and all healthcare providers about the malpractice system in the United States. **The conviction of this nurse for a tragic medication error will make all providers worry that reporting errors could move professional disciplinary procedures beyond the administrative/civil system to criminal proceedings. The culture of safety in health care rightfully puts patient safety first and mandates that all errors be reported. Best practices require that the entire process leading to the error undergo an investigation to make sure all gaps in safe process are corrected.** Nurses accused of malpractice appropriately undergo an investigation and review by the state authority that governs professional licensing. The individual must accept that outcome. From the beginning, Nurse Vaught admitted the medication error. The professional disciplinary process and eventual administrative action against Ms. Vaught's license are not in dispute. However, the rest of the system failed her. To protect patient safety and create accountability, all stakeholders must be honest and forthright throughout the process. The handling of this case raises troubling questions about every aspect of the investigation, response, and outcome.

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American Hospital Association & AONL

Robyn Begley, DNP, RN, chief nursing officer of the American Hospital Association, and CEO of the American Organization for Nursing Leadership.

- 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.

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Ignoring Lessons form the Past

- Turns back the clock after IOM *To Err is Human* (2000)

  "Human beings, in all lines of work, make errors. Errors can be prevented by designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing…

  Traditional clinical boundaries and a culture of blame must be broken down. But most importantly, we must systematically design safety into processes of care."

- **Danger: Fear of criminal convictions will prevent health care providers of all professions from reporting errors**

National Academies of Sciences, Engineering, and Medicine. 2000. To Err Is Human: Building a Safer Health System. Washington, DC: The National Academies Press. https://doi.org/10.17226/9728.

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Just Culture Analysis

- A Just Culture is Defined as : **A fair and consistent environment that fosters open communication, transparency, voluntary error reporting, information sharing and a willingness to do the right thing.**

- **Outcome:**
  - A system of justice (disciplinary and enforcement action) that reflects what we now know of socio-technical system design, human free will and our inescapable human fallibility.
  - Just Culture Algorithm™ doesn't lump all behaviors into one category but rather allows for each behavior to be evaluated separately to more effectively determine the root cause. It is a scientifically valid, legally-supported model that will work for the many and varied events and conducts faced by an organization.

https://www.outcome-eng.com/just-culture-the-foundation-of-an-effective-safety-culture/

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Just Culture Framework

"Just culture" – a stepped approach

Human Error	At-Risk Behaviour	Reckless Behaviour
An inadvertent action: *Slip, lapse, mistake*	***A choice;*** *e.g. a risk not recognized, or believed justified*	***Conscious disregard*** *of expectations (including fraud and/or corruption)*
Manage through changes in: • Processes • Procedures • Training • Design • Environment	Manage through: • Removal of incentives for at-risk behaviours • Create incentives for healthy behaviours • Penalties for increased risk factors • Increase situational awareness	Manage through: • Remedial measures • Punitive action, including dismissal/prosecution as appropriate.
Console individual	**Coach individual**	**Discipline/Sanction individual**

https://medium.com/ecajournal/why-why-why-analysing-the-root-causes-of-fraud-and-corruption-6236fd2a5ea9

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What's Next?

- Precedent for families to get a result that "punishes" someone who "harmed their loved one"
- Need a renewed focus on systems accountability and use of Just Culture
  - "First and foremost about prevention of harm"
  - "Managerial responsibility to design good systems and help employees make good choices"

https://www.outcome-eng.com/wp-content/uploads/2019/03/Vanderbilt-Homicide-A-Just-Culture-Analysis_David-Marx.pdf

- **Need for focused Professional Association advocacy on this issue**

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What ALL Nurses Need to Know

- Individual Malpractice Insurance
  - **Claims-made policy**: coverage in effect when the event occurs and when the lawsuit is filed
    - "Tail coverage" sometimes included; often expensive
  - **Occurrence policy**: coverage for any event while the policy is in effect even it lawsuit is filed after policy lapses
    - More expensive coverage

- Notify insurance provider immediately for any contact or subpoena
- Have legal counsel present for any investigative process related to a licensure action or lawsuit

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