Friday, April 29, 2022

# The Vanderbilt Case

## How UF Health Proactively Protects Patients & Providers

Special Report

**OVERVIEW**

**On March 25, 2022, a Vanderbilt nurse, RaDonda Vaught, was found guilty of negligent homicide and gross neglect of an impaired adult, after making a serious medical error that resulted in the patient coding and dying. These criminal charges are disturbing for many reasons and are not supported by the American Nurses' Association, the American Society for Health Care Risk Management or the Institute for Safe Medication Practices or many other organizations.**


**RaDonda was NOT reckless** — she was human.

This post will examine the facts in this matter, the pertinent laws in Tennessee and Florida, what happens at UF Health and what we can learn from this event.

**FACTS OF THE VANDERBILT CASE**

The patient, Charlene Murphey, was a 75-year-old female who was admitted to Vanderbilt University Medical Center with a subdural hematoma. The patient's medical status improved, but the physician ordered a positron emission tomography, or PET, scan on Dec. 26, 2017. Versed, a sedative, was ordered for the patient to undergo the scan. The nurse involved, RaDonda Vaught, R.N., was an experienced nurse who was a float nurse that shift and was working in the neurological intensive care unit, or Neuro ICU. Vaught was also orienting a new nurse and was called by Radiology to administer the Versed that had been ordered. When Nurse Vaught went to enter the patient's name in the automated medication dispensing cabinet in the Neuro ICU, the order did not appear. According to Vanderbilt's Medication Safety Officer, who testified at the trial, the hospital had some technical problems with medication cabinets in 2017, but the problem had resolved weeks before the incident.

**As Nurse Vaught did not find Versed on the profile — it was there but under its generic name — she overrode the patient's profile to search the dispensing cabinet for the Versed. In the override search, she typed in the first two letters "VE" and clicked on the first drug that appeared. That drug was not Versed, but rather VECURONIUM, a paralytic drug, and Nurse Vaught removed that drug from the system.**

Nurse Vaught then went to Radiology and looked for a scanner, to scan the patient's arm bracelet with the drug, but there was no scanner in Radiology. Nurse Vaught then administered the drug and left Radiology, after assurances from the Radiology tech that he/she would be watching the patient. Moments later, while Nurse Vaught was in the emergency department providing assistance for another patient, she heard that a Code was being called in Radiology. When she arrived, she saw that it was Ms. Murphey, the patient for whom she administered the medication. When asked what she gave the patient, she retrieved the bottle and immediately realized that she had given VECURONIUM instead of VERSED.

**She admitted to her error.**

Although Ms. Murphey was resuscitated, her prognosis remained grim, and the family decided to withdraw care. Ms. Murphey was pronounced dead on Dec. 27, 2017.

**Because Nurse Vaught did not document the error in the medical record, the death certificate and the Medical Examiner's Report documented that the patient died from natural causes, as there was no mention of the Vecuronium in the medical record.**

**MISSED OPPORTUNITIES**

- Nurse Vaught overrode the automated dispensing software to get the Versed, but unintentionally pulled the Vecuronium (see the Institute for Safe Medication Practices, or ISMP, discussion of just how frequently providers conduct overrides to obtain medications for administration). https://www.ismp.org/resources/over-top-risky-overuse-adc-overrides-removal-drugs-without-order-and-use-non-profiled
- She did not confirm the drug at the time of removing it from the cabinet.
- She did not confirm the drug at bedside.
- She did not stay with the patient to monitor her reaction to the drug.
- She apparently did not recognize the warning sign provided by the physical difference between the two drugs: Vecuronium is available in powder form and requires reconstitution, unlike Versed, which is only available in liquid form.
- She did not notice the lid on the vial that said, "Warning Paralyzing Agent."

**TIMELINE OF VANDERBILT CASE**

## Vanderbilt settled this case early, but never reported this incident to the state as a serious medical error.

Then, in October 2018, an anonymous caller notified the Centers for Medicare and Medicaid Services, or CMS, who then investigated the incident. The Tennessee Department of Health, or DOH, investigated this matter but decided not to pursue disciplinary action against Nurse Vaught. However, when CMS confirmed that Vanderbilt did not report the fatal medication error, CMS went public with their findings the following month. In February 2019, the Tennessee District Attorney filed criminal charges against Nurse Vaught for reckless homicide and impaired adult abuse. Due to the COVID-19 pandemic, the case remained dormant for 2020 and 2021. DOH then reopened its licensure investigation of Nurse Vaught and decided to pursue disciplinary actions. In July 2021, at a disciplinary hearing, the Board of Nursing revoked Nurse Vaught's nursing license.

**COULD THIS HAPPEN TO ME AT UF HEALTH? WHAT ARE THE HOSPITAL REGULATORY REQUIREMENTS?**

In states like Tennessee and Florida, licensed hospitals and ambulatory care centers are required by law to report serious incidents to the state within a short time period of the event or knowledge that the event caused the injury. In Florida, serious incidents include death or brain or spinal damage due to an adverse incident, meaning, "an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred."

## The serious incident report or "Code 15 Report" must include the incident description, the health care providers involved as well as witnesses, an analysis of the event and corrective actions that the facility undertook or is undertaking to ensure future loss prevention measures have been put into place. In the Vanderbilt case, the event was not reported to the state nor was there documentation of the error in the medical record.

Since Vanderbilt did not appear to follow standard record keeping and reporting processes, opportunities were lost to review the event for system errors. Conversely, had Vanderbilt used the Just Culture Analysis embraced by UF Health, a prompt and documented disclosure of the error to the county medical examiner, other state officials, and to the patient's family would have occurred. Additionally, at UF Health a thorough evaluation of system errors and implementation of patient-safety improvements would have been put in place.

**LET'S LOOK AT A SIMILAR EVENT THAT OCCURRED AT UF HEALTH AND CONTRAST IT TO THE CIRCUMSTANCES IN THE VAUGHT CASE.**

Sebastian Ferrero was a 3-year-old boy undergoing a growth hormone study. As part of that study, the nurse was supposed to administer 5.75 grams of arginine, a growth hormone, in an infusion IV. Pharmacy had profiled the drug, but sent two bottles of the drug for a total of 60 grams (30 grams per 300 mL bottle), and the bottles were labeled 1 of 2 and 2 of 2. Although the nurse recalculated the 5.75-gram dose based on the child's body weight, the nurse thought that she had to give both bottles of arginine as she didn't appreciate that she only had to give 57.5 mL (1 gram per 10 mL). A physician did evaluate the patient, but did not realize the amount that was being infused. The child then died two days later. See https://www.ismp.org/resources/fatal-overdose-uncovers-need-rethink-where-pediatric-iv-medications-are-dispensed-and for more details on the event.

As soon as the error was discovered, the parents were given disclosure regarding the events. This disclosure was then documented in the medical record. The medication bottles were immediately retrieved, the medical examiner was immediately notified of the error that caused the child's death, the incident was reported to the State as a Serious Incident, the health care providers were supported while the investigation was ongoing, and the UF Self-Insurance Program settled the civil negligence lawsuit on behalf of the hospital and UF college of medicine within months of the event. None of the health care providers lost their licenses and no criminal lawsuits occurred.

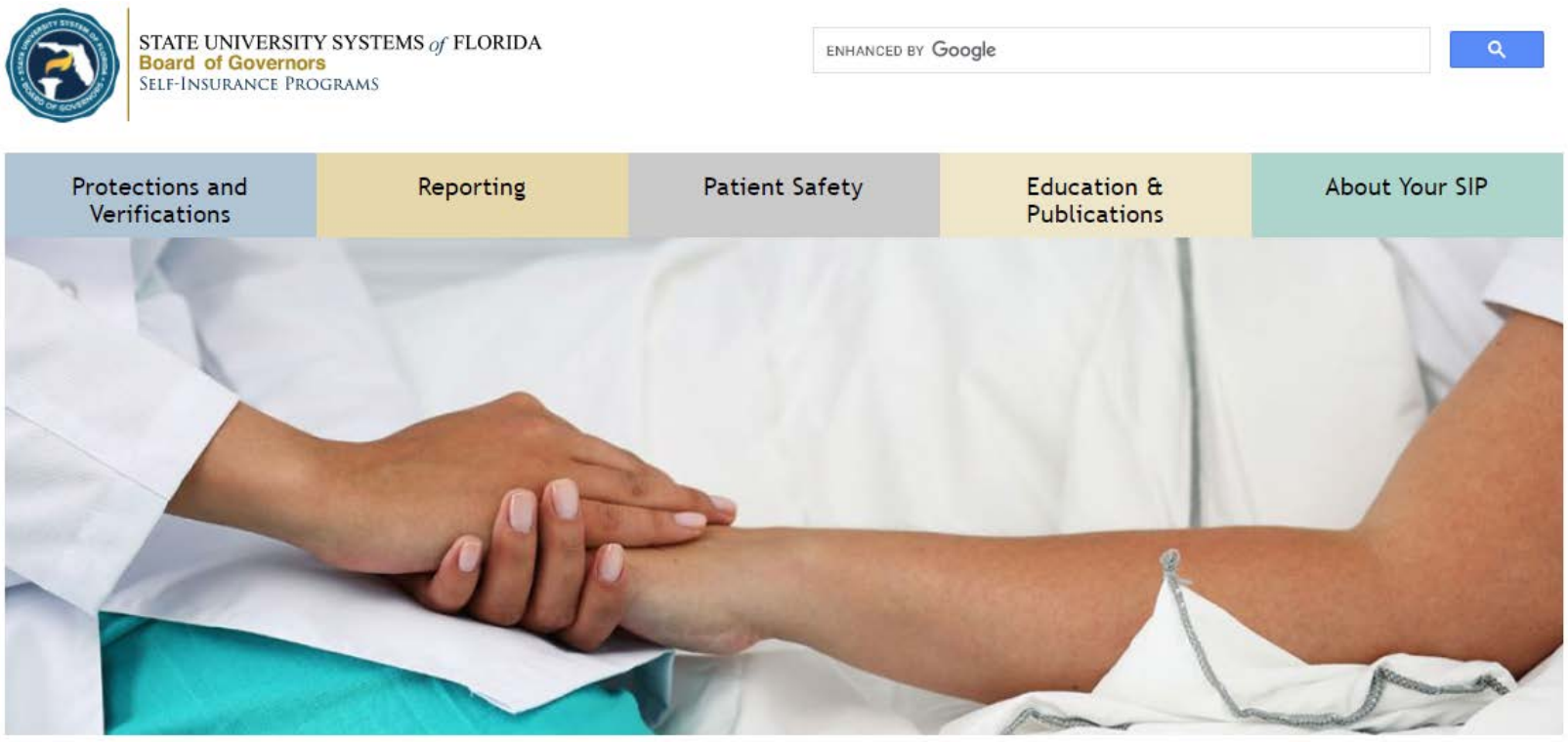
**SYSTEM OPPORTUNITIES**

## As a result of the early civil settlement with the family, the Sebastian Ferrero Office of Clinical Quality and Patient Safety was established. The involved licensed providers returned to work. The Self-Insurance Program also successfully handled the licensure defense for the involved health care providers (nurses, pharmacists, physicians). There were no criminal charges filed by the State.

After the Ferrero event, multiple system related safeguards were updated and implemented. Additionally, a high alert medication Policy went into effect in 2005. This policy has been revised over time and was reviewed again after news of the Vanderbilt case came to light in 2019. UF Health continues to review this policy on a regular basis, looking for any type of possible safety improvements. For more information on this policy, please go to https://bridge.ufhealth.org/policies/high-alert-medication/.

**CONCLUSION**

UF Health will continue to support our nursing and all of our health care providers using our Just Culture approach to patient care. Additionally, UF Health staff, including nursing staff, who are acting within the scope of their employment are provided professional and comprehensive general liability protection by the State University Systems of Florida Self-Insurance Program, which also includes licensure defense for patient care events. Some have requested information for how the laws of Tennessee differ from the laws of Florida. A brief description follows this article. For a more detailed understanding, request for a department in person presentation, or other questions, please call SIP at 352-273-7006 or 844-MY FL SIP.




# Tennessee vs Florida Legal Framework:

**TENNESSEE'S LEGAL FRAMEWORK**

**The Criminal Charges:** The Tennessee District Attorney charged Nurse Vaught with Reckless Homicide, Negligent Homicide and Gross Neglect of an Impaired Adult.

**Jury Verdict: Nurse Vaught was acquitted of reckless homicide but convicted of the lesser offense of criminally negligent homicide.**

**The Elements of Criminally Negligent Homicide:** Tennessee law states that criminally negligent homicide is criminally negligent conduct that results in death. Any level of negligence causing the death of another can be charged as criminally negligent homicide, even if the negligence does not rise to the level of reckless negligence, gross negligence, or willful and wanton negligence.

**Nurse Vaught was also convicted of gross neglect of an impaired adult.** Tennessee law states that 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.

**FLORIDA'S LEGAL FRAMEWORK**

Florida law differs from the law in Tennessee with respect to criminal liability for negligent acts that cause death. **There are no** criminal offenses in Florida similar to Tennessee's criminally negligent homicide offense of which Nurse Vaught was convicted. Unlike that Tennessee law, **Florida law does not hold persons criminally liable for deaths caused by ordinary breaches of the standard of care or simple negligence.**

For a person to be criminally at fault for a death occurring by negligence in Florida, a person must have caused the death of another through **"culpable negligence"** which is **more than a failure to use ordinary care**. It is negligence that is **gross and flagrant**, and is a course of conduct demonstrating **reckless and grossly careless disregard of human life, or of the safety of persons or conscious indifference.** In Florida, therefore, **only if a person's negligence rises to the extremely high and gross level of negligence, known as "culpable negligence," will a person be criminally liable for the unintentional death of another person.**

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