Criminalization of Medical Errors and Risks to Health Care Quality and Safety

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Friday, May 13, 2022 - Vaught: Sentenced to three years probation

"Davidson County criminal court Judge Jennifer Smith granted Vaught a judicial diversion, which means her conviction will be expunged if she completed a three-year probation."

https://dailynurse.com/judge-allows-radonda-vaught-to-expunge-conviction-following-3-year-probation-term/amp/

- Convicted of criminally negligent homicide and gross neglect of an impaired adult, Vaught faced up to eight years in prison.
- Permanent loss of registered nurse license.

Now that sentencing is probation and does not include prison time, is this discussion important?

“We cannot punish our way to safer medical practices.”

IOM. (2000). To err is human: building a safer health system

What is the value in continuing this conversation with the Washington Patient Safety Coalition (WPSC) Team?

- To determine if the WPSC might have a role in addressing this issue.
- To identify actions that WPSC might undertake together.

Objectives for today

- Review criminalization of medication errors.
- Identify care quality and safety risks associated with the criminalization of medical errors.
- Discuss principles and practices that support a just and safe culture in the workplace.
- Review challenges in rapid event response and analysis (case study)
- Discuss Washington Patient Safety Coalition's potential role and actions.

Background

- No deluge of criminalization of medication errors.
- Health care practice issues have historically been addressed through the licensing board and/or civil litigation

Medical Malpractice Lawsuits

"An act or omission (failure to act) by a medical professional that deviates from the accepted medical standard of care."

- Relatively common in the U.S.
- Medical lawsuits – usually civil (not criminal).
- Civil suit occurs between two parties.
  - Results in fines and not incarceration.
- Injured individual must show the health care provider failed to exercise the appropriate level of care.
- Negligence is more common in civil cases than criminal.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628513/

Elements of Crime

Historically consisted of:

- **Conduct** = a guilty act (Actus Reus) <u>and</u>
- **Intent** to cause harm (Mens Rea)

Crime = a guilty act + intent to harm another person.

Recent shift:

- Criminal liability = Guilty act without intent to cause harm.

https://legaljobs.io/blog/elements-of-a-crime/

Criminalization of Medication Error
Three Cases

Criminal Cases: Medication Error

1996: Golz-NNP; Fitchett-Nursery Nurse; King-M/B Nurse

Felony charge - criminally negligent homicide

2006: Thao, RN – St. Mary Hospital, Madison, WI

Felony charge – criminal neglect

2017: Vaught, RN – Vanderbilt University Medical Center

Felony charge – criminally negligent homicide

1996: Centura St. Anthony Hospital

- Infant death – ten-fold overdose of IM medication penicillin G benzathine administered by IV route.
- Three nurses indicted on charges of negligent homicide.
- First known incident of nurses criminally charged for a fatal medication error.
- ISMP provided in depth system analysis of the medication error and expert testimony at the trial.
- 50 different system failures identified that allowed error to develop and reach the infant.

https://web-p-ebscohost-com.offcampus.lib.washington.edu/ehost/pdfviewer/pdfviewer?vid=0&sid=5e430089-dcd5-45b3-b32d-9cc5ccb82131%40redis

https://www.ismp.org/resources/lesson-denver-look-beyond-blaming-individuals-errors

2006: St. Mary's Hospital

- Epidural anesthetic was withdrawn without an order, along with penicillin (with order).
- Epidural marked "not for IV use" administered intravenously.
- Patient seized/died.
- First Wisconsin criminal charge for a medical mistake.
- Charged with felony criminal neglect; pleaded guilty to two misdemeanors.
- License suspended for 9 months with a 5-year ban from working in hospitals
- ISMP conducted an RCA one year after the occurrence.

https://www.ismp.org/news/ismp-opposes-criminal-charges-wisconsin-nurse-involved-medication-error

https://www.reliasmedia.com/articles/101137-nurse-charged-with-felony-in-fatal-medical-error

https://www.truthaboutnursing.org/news/2006/nov/20_captimes.html#gsc.tab=0

2017: Vanderbilt University Medical Center

Vaught Timeline

- Fatal medication error December 2017.
- Arrested 2019.
- Convicted March 2022 - Gross neglect of an impaired adult and negligent homicide.
- Jury included health care workers.
- Faces 3-6 years in prison for neglect and 1-2 years for negligent homicide.
- Sentenced on May 13, 2022 - 3 years probation with possibility of expunging from record.

2017: Vanderbilt University Medical Center

- Versed ordered for anxiety prior to a scan.
- Nurse was unable to locate Versed in the automated dispensing cabinet (ADC). Enabled **override** and searched "VE."
- Unknowingly extracted a paralytic agent from the ADC– reconstituted/administered Vecuronium in error.
- Distracted – orienting a new nurse
- Neglected to see warning labels on vial.
- Did not monitor the patient following administration.
- Patient experienced unwitnessed respiratory arrest and expired the next day.

VECURONIUM
BROMIDE
FOR INJECTION
10 mg*

WARNING: PARALYZING AGENT

How frequently do registered nurses report using “override” to access medications from automated dispensing cabinets?

In a multitasking world, does distraction/interruption still cause problems or have health care professionals adapted?

2017: Vanderbilt University Medical Center

- Initial investigation by the Tennessee Department of Health = no discipline .
- Four month later – Tennessee Bureau of Investigation
    - Charged with reckless homicide and impaired elder abuse.
    - Charges include prison and fines.
- 9/2019, Tennessee DOH reversed decision and filed with Tennessee Board of Nursing for "unprofessional conduct" and "abandoning or neglecting" a patient.
- License revoked + fines sanctioned

Criminalizing Medical Error:
Risks to Quality and All Person Safety

Effects of punishing errors
Culture of blame

Reluctance to report

Hide errors and omissions

Prevent investigation and cause analysis

Stunt performance improvement

Perpetuate harm

“We cannot punish our way to safer medical practices.”

IOM. (2000). To err is human: building a safer health system

Institute for Health Care Improvement
Lucian Leape Institute

"Criminal prosecution over-focuses on the individual and their behavior and diverts needed attention from system-level problems and their solutions. This is not how safety is achieved in health care."

IHI. (2022). IHI and LLI Statement About the Risks to Patient Safety When Medical Errors are Criminalized. Retrieved from http://www.ihi.org/about/news/Documents/IHI,%20LLI%20Statement_FINAL.pdf

Institute for Health Care Improvement
Lucian Leape Institute

"We know from decades of work in hospitals and other care settings that most medical errors result from flawed systems, not reckless practitioners. We also know that systems can learn from errors and improve, but only when those systems encourage reporting, transparently acknowledge their mistakes, and are held accountable for those errors."

IHI. (2022). IHI and LLI Statement About the Risks to Patient Safety When Medical Errors are Criminalized. Retrieved from http://www.ihi.org/about/news/Documents/IHI,%20LLI%20Statement_FINAL.pdf

Washington Law

RCW 70.41.200

- Quality improvement/medical malpractice prevention program

https://app.leg.wa.gov/rcw/default.aspx?cite=70.41.200

RCW 70.41.380

- Disclosure of unanticipated outcomes is provided to patients/families; this does not constitute an admission of liability

https://app.leg.wa.gov/RCW/default.aspx?cite=70.41.380

RCW 5.64.010

- Any gesture or conduct expressing apology, fault, or remedial actions to address the act or omission and provided within 30 days of the event, is not admissible for civil action

https://app.leg.wa.gov/rcw/default.aspx?cite=5.64.010

Reflection

What effect do you believe criminalization of medical error will have on disclosure of unintended outcomes to patients/ families/decision-makers?

1. No effect on disclosure of unintended outcomes
2. Some effect on disclosure of unintended outcomes
3. Significant decrease in disclosure of unintended outcomes

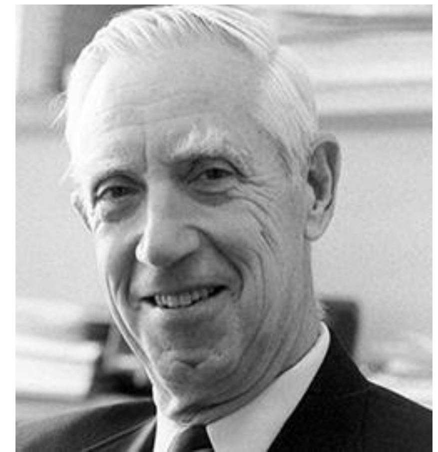
A Safe, Fair, and Just Culture in Every Health Care Organization

Serious Adverse Event Response

1. Minimize further patient harm and relieve *suffering*
2. Transparently report using chain of command/incident reporting
3. Transparently communicate to the patient/family including what happened, why it happened, and actions to prevent reoccurrence
4. Sincerely apologize
5. Provide immediate and long-term support to staff
6. Conduct a thorough investigation and commit to doing what is right
7. Identify lessons learned, incorporate into practice and share with stakeholders
8. Address near-misses before they become serious safety events

IHI. (2022). IHI and LLI Statement About the Risks to Patient Safety When Medical Errors are Criminalized. Retrieved from http://www.ihi.org/about/news/Documents/IHI,%20LLI%20Statement_FINAL.pdf

Just Culture



"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes."

Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before Congress on Health Care Quality Improvement
January 25, 2000

Engage in Culture of Safety Practices

Proactively clarify your work assignment

Identify expert resources

Follow policy and procedure

Optimize use of huddles

Teamwork

Raise concerns

“If you see something, say something”

Use chain of command

Committees

Professional Practice Considerations

Mindfulness – intentionally stay in the moment

Minimize distractions & interruptions

Self-check STOP-THINK-ACT-REVIEW

Resolve issues before proceeding

Communicate using CUS

Consistently complete incident reports

Consider professional liability insurance

Inquiry Ideas

- What systems issues contributed to this error or near miss?
- Do you believe that those involved with the error felt safe to report?
- Are there resources for immediate assistance with an adverse event?
- Will lessons learned from this adverse event be shared with other areas to prevent the same or similar events from happening in the future?

Just Culture Refresher

Just Culture "Refresher"

Human Error

Just Culture “Refresher”

At-Risk Behavior

Just Culture "Refresher" – Reckless Behavior

Why Just Culture?

- To learn from mistakes/errors in an environment where sharing is the “norm”
- To create an environment where **systems and processes** are continually improved
- To promote individual accountability for behavioral choices within one’s control
- To build trust and transparency in all that we do

Marx, D. (2009). Whack a mole.

Performance Management Decision Guide

Adapted from James Reason's *Decision Tree for Determining the Culpability of Unsafe Acts* and the *Incident Decision Tree* of the National Patient Safety Agency (United Kingdom National Health Service)

Start

Deliberate Act Test

D1 Did the individual intend the act? — No → I1; Yes → D2

D2 Did the individual act with malicious intent (i.e. to cause physical/mental harm or other damage)? — No → I1; Yes → Malevolent or Willful Misconduct

Incapacity Test

I1 Is there suspicion of ill health, a medical condition, or substance abuse? — No → C1; Yes → I2

I2 *If ill health or a medical condition:* Was the individual aware of the ill health or medical condition? — Yes → C3; No → Suspected Medical Condition and/or Substance Abuse

Compliance Test

C1 Did the individual depart from policies, procedures, protocols, or generally accepted performance expectations? — No → S1; Yes → C2

C2 Were the policies, procedures, protocols, or performance expectations available, understandable, workable, and in routine use? — No → S1; Yes → C3

C3 Is there evidence that the individual chose to take an unacceptable risk **OR** has a trend in poor performance or decision making? — No → S2; Yes → C4

C4 Were there significant mitigating circumstances that justify the act in this case? — Yes → S2; No → Possible Reckless or Negligent Behavior

Substitution Test

S1 Would individuals in the same profession and with comparable knowledge, skills, and experience act the same under similar circumstances? — Yes → Possible System Induced Error; No → S2

S2 Were there any deficiencies in related training, experience, or supervision? — Yes → Possible System Induced Error; No → Possible Unintended Human Error

Outcomes

Malevolent or Willful Misconduct

Actions to Consider
(Consult Human Resources)
- Disciplinary action
- Report to professional group or regulatory body
- Law enforcement referral

Identify Contributing System Factors

Suspected Medical Condition and/or Substance Abuse

Actions to Consider
(Consult Human Resources)
- Occupational health referral
- Adjustment of duties
- Leave of absence

If substance abuse:
- Substance abuse testing
- Disciplinary action

Identify Contributing System Factors

Possible Reckless or Negligent Behavior

Actions to Consider
(Consult Human Resources)
- Disciplinary action
- Job-fit consideration

Identify Contributing System Factors

Possible Unintended Human Error

Actions to Consider
(Consult Human Resources)
- Console
- Coaching
- Mentor assignment
- Increased supervision
- Performance improvement plan
- Adjustment of duties

Identify Contributing System Factors

Possible System Induced Error

Console and/or Coach the Individual **AND** Find & Fix Process Problems

Revision 4, July 2009
Healthcare Performance Improvement, LLC

https://hartfordhospital.org/file%20library/policies/prehospital%20ems/disciplinary-action-and-system-suspension-2018_01_18.pdf

Case Study: Overcoming Common Challenges in Rapid Event Response and Analysis

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Questions?

- What role might the WPSC take (if any) in addressing issues identified?
- Are there specific actions that the WPSC might undertake together?