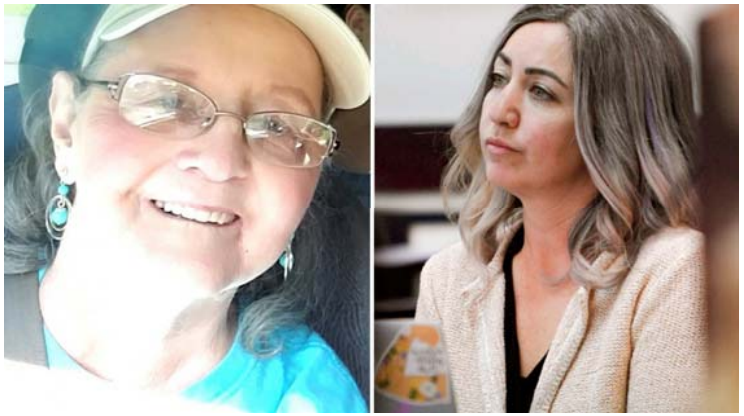


Patient Safety: What can we learn from Charlene Murphey (patient)/RaDonda Vaught (nurse) Case?

How to Create Meaningful and Lasting Change using New Agreement Model

Presented by

Soojin Jun, PharmD, BCGP, CPPS, CPHQ

Cofounder of Patients for Patient Safety US

& David Dibble

Founder & CEO, New Agreements, Inc

https://www.tennessean.com/story/news/health/2019/02/04/vanderbilt-deadly-vecuronium-error-victim-would-forgive-nurse-son-says/2774381002/ (Courtesy of Murphey family)
https://fox17.com/newsletter-daily/family-of-victim-killed-after-former-nurse-issued-paralyzing-drug-speaks-out-to-backlash (AP)

Speaker Disclosure

Speakers have no conflicts of interest to disclose.

Patients for Patient Safety US (PFPS US)

- Launched in 2021 by a group of leading patient safety activists
- United in frustration about the state of patient safety in the US
- Established as a chapter of WHO's PFPS global network
- Actively working to engage US leadership partners to the state of patient safety in the US

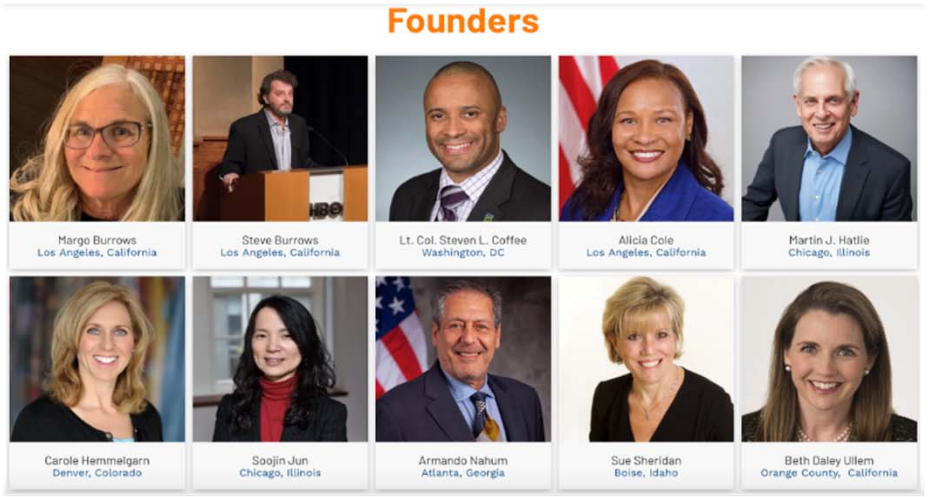
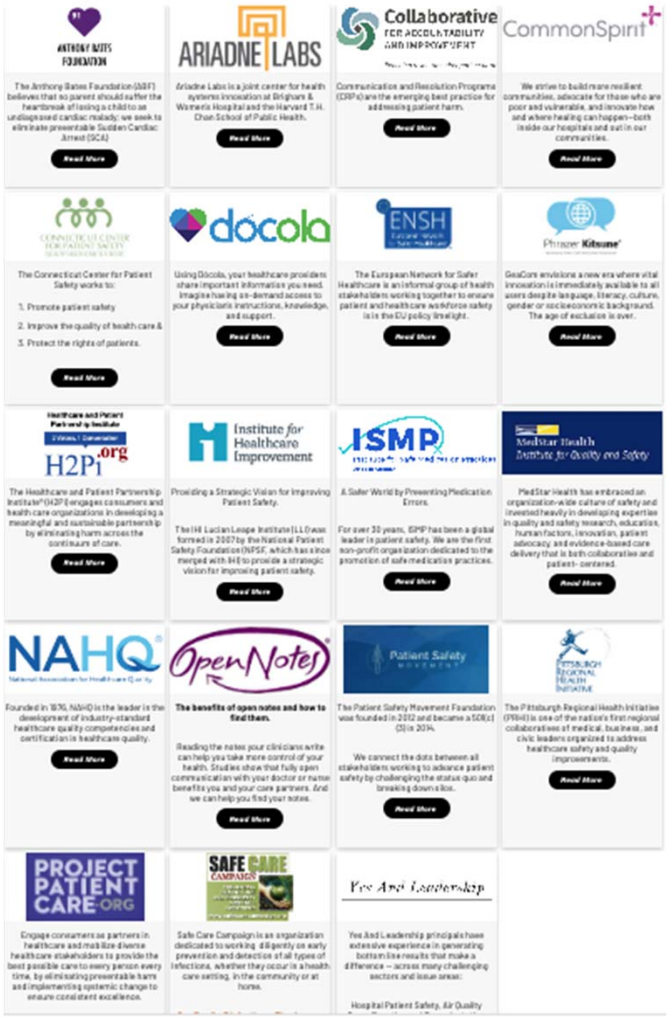


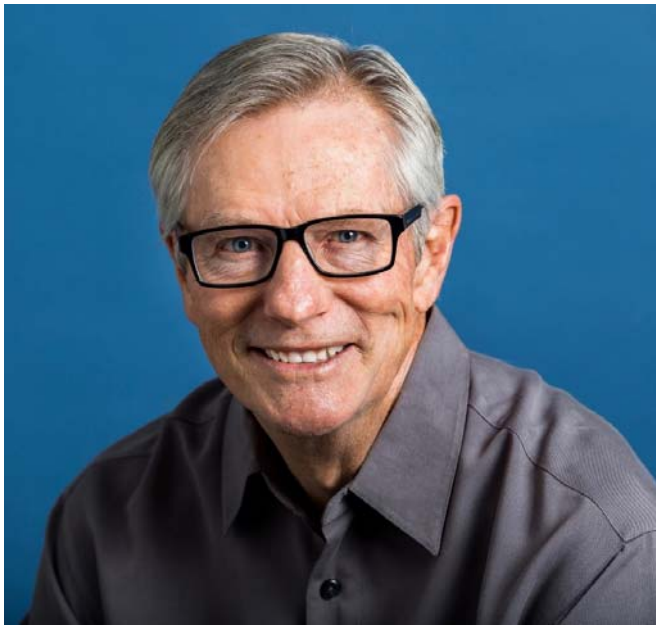
Image: www.pfps.us/about-us (used with permission)

PFPS US

Current Strategic Partners from our website

Check us out at www.pfps.us!





David Dibble

1990 – Present -- New Agreements Consulting & Training
Provides systems-based business performance enhancement consulting and training. Provides executive level,emerging leader, and manager business coaching and training services, specializing in The New Agreements Model for organizational change and growth with guaranteed ROIs for most clients.

Author of:
The New Agreements for Leaders
The New Agreements in the Workplace
The New Agreements in Healthcare
DreamWork—VisionWork
CharacterTypes – Models for Thinking

Check his work at www.thenewagreements.com

Objectives

1. Discuss the Murphey/Radonda Vaught case to establish common ground and understand the case.

2. Differentiate between empathy and compassion and how each factor into the handling of a medication safety event.

3. Apply a resolution model to the case.

Takeaway points

1. Notice the need for safety to even discuss the safety event itself without blame, shame, resentment, and scapegoating.

2. 5 elements of empathy in discussion and noticing the difference from compassion

3. Active learning and application: Intro to New Agreement model

Outline of the session

- What happened in Murphey/Vaught Case?

(Pay attention to Characters in the story—who would you rather be?)

- Why is this case important in patient safety and healthcare?
- What can we learn from the case?
- Empathy & Compassion Exercise
- Now what do we do?
- New Agreement Model Exercise applied to the case

Murphey/Vaught Case Timeline

- 10/2015
- RaDonda Vaught

Starts working at Vanderbilt

- 1000 bed
- Acute care hospital

- 12/26/2017
- Charlene Murphey admitted for subdural hematoma
- PET scan ordered before discharge
- Versed (midazolam) ordered for anxiety
- RaDonda working as a float nurse that day and precepting a student on her way to do a swallow-test for another patient
- Primary nurse asks RaDonda to administer Versed
- Vecuronium was taken out from the Auto-dispensing cabinet (first 2 letters, VE was typed and Versed was not there, after overrides, 3 warnings)
- Vecuronium reconstituted and injected, Ms Vaught onto the task she was assigned without monitoring Ms Murphey
- Ms Murphey found unresponsive 30 min later
- RaDonda admits mistake

- 12/27/2017
- Charlene Murphey disconnected from breathing machine
- 2 neurologists put the cause as natural bleeding on Coroner's report

- 01/ 2018
- Vanderbilt did not report the error as required by federal law
- RaDonda was fired
- 05/2018
- RaDonda gets a job at Tristar Medical Center as Throughput coordinator

Murphey/Vaught Case Timeline continued

Blake Farmer/WPLN News

- Early 2018
- Vanderbilt settles with the family
- Oct 2018
- Anonymous complaint alerted state and government official
- CMS investigation starts and end Nov ‘18, the case goes public
- Feb 2019
- RaDonda arrested with reckless homicide, mistake and not reporting admitted by hospital CEO for the first time
- Tennessee Board of Licensing Health Care Facilities does not discipline hospital
- Aug 2019
- Death certificate’s cause of death changed to med error
- Sept 2019
- The Tennessee Department of Health reverses its prior decision not to pursue professional discipline against Vaught and charges her that could result in license revocation
- Covid-19 puts halt on proceedings
- July 2021
- Vaught loses nursing license
- March 2022
- Criminal trial begins
- Vaught was found guilty of criminally negligent homicide and gross neglect of an impaired adult in 3’22 (lesser charge of reckless homicide)
- National outrage among nurses and patient safety organizations
- May 2022
- Sentencing with 3 years probation

Murphey/Vaught Case

-What is your thought about the case? Describe the feeling in one word and share.

-What are the opportunities to improve?

-Think about the stakeholders in the case and be in their shoes to imagine what you would have done: (Choose one character and share how you feel on whether you agree/disagree or just general feeling)

-administrator of the hospital, director of pharmacy, patient safety officer, family, patient, judge, jury, and nurses (Imaginative empathy)

-How can we take the lessons learned and apply to your organizations?

Pause & Think

Role Play

Partner & Discuss

(10 min.)

HEALTH + CARE

EMPATHY COMPASSION

Image credit:
https://www.vecteezy.com/vector-art/6961870-simple-love-shape-with-oak-tree-inside
Simple love shape with oak tree inside Vectors by Vecteezy (allowed to use attribution)

5 Steps in Empathy

1. Self-empathy: how do you intend to show up? (awareness)
2. Kinesthetic empathy: bias, perception, sensation, emotions (sharing)
3. Reflective empathy: listening to reflect (mirroring)
4. Imaginative empathy (imagining in that person's perspective)
5. Empathic creativity: measurable, actionable outcome (compassion)

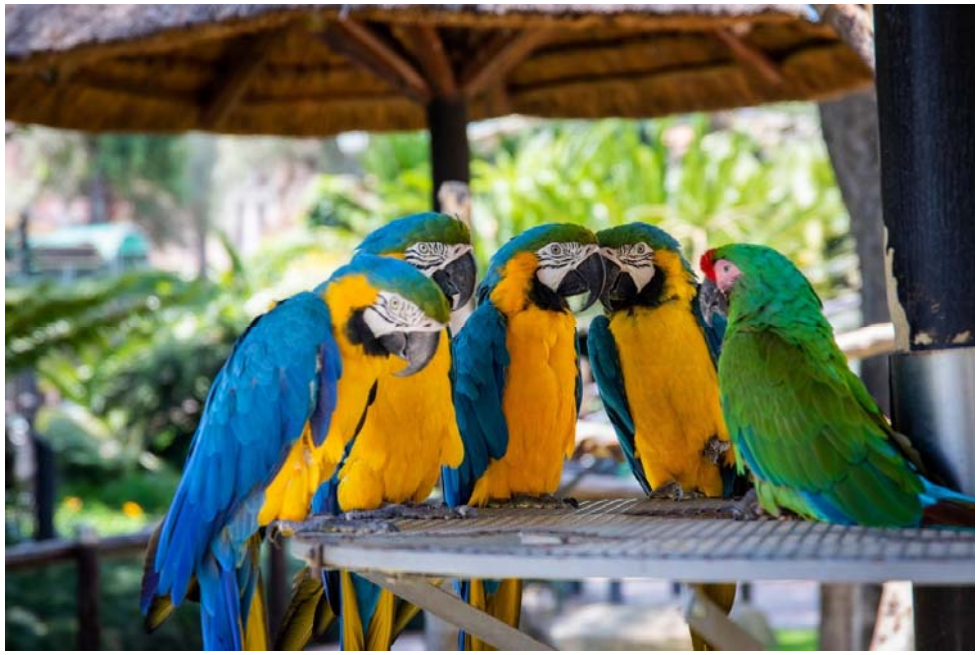


Photo by Magda Ehlers: https://www.pexels.com/photo/parrots-perched-on-brown-wooden-surface-1599452/ (Free to use with credit)

From: https://empathicintervision.com/empathic-intervision/

Pause & Think

1. Be Impeccable with your word
2. Don’t take anything personally
3. Don’t make assumptions
4. Always do your best

Image: https://www.amazon.com/Four-Agreements-Practical-Personal-Freedom/dp/1878424319?author-follow=B001JP23NM

David’s Video on New Agreements Model

Live exercise on 3D:

Discovery
Distill
Define

David's Video on New Agreements Model Applied

7 tools: Disruptive Discovery, Distillation & Naming, 80/20 Rankings, Taking Right Action/Right Sequencing, Real-Time Reporting & Communication, Right Measurement, New Agreements Facilitation

3D: Discovery, Distillation, Defining

Code of silence for mistakes
We can't admit errors
Hospital won't admit errors
We're punished if we make mistakes
We're considered disruptive if we speak up
We get shunned by our peers when we make mistakes
Management is the enemy when we make mistakes
Management does PR spins when mistakes are made
Families are not told the truth when we make mistakes
Patients are not told the truth when we make mistakes
When there's a problem, we blame people instead of fixing systems
There are so many things to remember, it's easy forget or be distracted
The med system is a joke
The med system is broken a lot of the time
Problems with the med system don't ever seem to get fixed

Some of us don't have good training on the med system
Nurses are going to leave because of this
The hospital should be prosecuted
In healthcare, the little people always get screwed
The system was not transparent about the cause of death on death certificate.
The system did not report the error as they should have with CMS.
The nurse was blamed and criminalized for everything
Leaders tried to sweep everything under the rug
Leaders focused on saving the hospital instead of supporting the nurse
The hospital never was accountable for anything
We missed a learning opportunity because the mistake was covered up
Float nurse in different units has too much to do
Float nurse in different units has too many distractions
Med system didn't work right—too many overrides
Med system override allowed wrong med after typing first two letters
High risk meds stored with all other meds
No barcode scanner to scan before injection.
Nurse not told to monitor patient after giving the injection.
Nurse had a student to oversee while multitasking.
Nurse didn't have a fair trial
Nurse had no support for her mistake internally
Nurse fired and career destroyed
Nurse held criminally responsible for systems problems

David's Video on New Agreements Model Applied

3D: Discovery, Distillation, Defining

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Mistakes

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Truth

Some of us don't have good training on the med system

System

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Nurse

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Mistakes

2. Truth

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1. System

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Nurse

Wrap-up

1. Patients first in patient safety—open and honest communication with family & beyond
2. Need for psychological safety for healthcare professionals to even discuss the case with fairness
3. Empathy & Compassion → Transformation
4. New Agreement Model—turning negative energy into positive, giving power and choice to change to the workforce, end burnout, and bring real transformation of healthcare

Questions