



## **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

### Founders



Margo Burrows  
Los Angeles, California



Steve Burrows  
Los Angeles, California



Lt. Col. Steven L. Coffee  
Washington, DC



Alicia Cole  
Los Angeles, California



Martin J. Hatlie  
Chicago, Illinois



Carole Hammelgarn  
Denver, Colorado



Soojin Jun  
Chicago, Illinois



Armando Nahum  
Atlanta, Georgia



Sue Sheridan  
Boise, Idaho



Beth Daley Ullem  
Orange County, California



















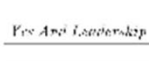



Image: [www.pfps.us/about-us](http://www.pfps.us/about-us) (used with permission)



# Current Strategic Partners from our website

Check us out at [www.pfps.us!](http://www.pfps.us!)

 <p><b>ANTHONY BIETS FOUNDATION</b></p> <p>The Anthony Biets Foundation (ABF) believes that no parent should suffer the heartbreak of losing a child to an undiagnosed cardiac malady; we seek to eliminate preventable Sudden Cardiac Arrest (SCA).</p> <p><a href="#">Read More</a></p>	 <p><b>ARIADNE LABS</b></p> <p>Ariadne Labs is a joint center for health systems innovation at Brigham &amp; Women's Hospital and the Harvard T.H. Chan School of Public Health.</p> <p><a href="#">Read More</a></p>	 <p><b>Collaborative for Accreditation and Improvement</b></p> <p>Communication and Resolution Programs (CRPs) are the emerging best practice for addressing patient harm.</p> <p><a href="#">Read More</a></p>	 <p><b>CommonSpirit</b></p> <p>We strive to build more resilient communities, advocate for those who are poor and vulnerable, and innovate how and where healing can happen—both inside our hospitals and out in our communities.</p> <p><a href="#">Read More</a></p>
 <p><b>CONNECTICUT CENTER FOR PATIENT SAFETY</b></p> <p>The Connecticut Center for Patient Safety works to:</p> <ol style="list-style-type: none"> <li>1. Promote patient safety</li> <li>2. Improve the quality of health care</li> <li>3. Protect the rights of patients.</li> </ol> <p><a href="#">Read More</a></p>	 <p><b>docoba</b></p> <p>Using Docoba, your healthcare providers share important information you need. Imagine having on-demand access to your physician's instructions, knowledge, and support.</p> <p><a href="#">Read More</a></p>	 <p><b>ENSH</b></p> <p>The European Network for Safer Healthcare is an informal group of health stakeholders working together to ensure patient and healthcare workforce safety in the EU policy framework.</p> <p><a href="#">Read More</a></p>	 <p><b>GenCare</b></p> <p>GenCare envisions a new era where vital innovation is immediately available to all users despite language, literacy, culture, gender or socioeconomic background. The age of exclusion is over.</p> <p><a href="#">Read More</a></p>
 <p><b>H2P1</b></p> <p>The Healthcare and Patient Partnership Institute (H2P1) engages consumers and healthcare organizations in developing a meaningful and sustainable partnership by eliminating harm across the continuum of care.</p> <p><a href="#">Read More</a></p>	 <p><b>Institute for Healthcare Improvement</b></p> <p>Providing a Strategic Vision for Improving Patient Safety.</p> <p>The IHI Lucian Leape Institute (LLI) was formed in 2007 by the National Patient Safety Foundation (NPSF), which has since merged with IHI to provide a strategic vision for improving patient safety.</p> <p><a href="#">Read More</a></p>	 <p><b>ISMP</b></p> <p>A Safer World by Preventing Medication Errors.</p> <p>For over 20 years, ISMP has been a global leader in patient safety. We are the first non-profit organization dedicated to the promotion of safe medication practices.</p> <p><a href="#">Read More</a></p>	 <p><b>MedStar Health</b></p> <p>MedStar Health has embraced an organization-wide culture of safety and invested heavily in developing expertise in quality and safety, research, education, human factors, innovation, patient advocacy, and evidence-based care delivery that is both collaborative and patient-centered.</p> <p><a href="#">Read More</a></p>
 <p><b>NAHQ</b></p> <p>Founded in 1976, NAHQ is the leader in the development of industry-standard healthcare quality competencies and certification in healthcare quality.</p> <p><a href="#">Read More</a></p>	 <p><b>OpenNotes</b></p> <p>The benefits of open notes and how to facilitate them.</p> <p>Reading the notes your clinicians write can help you take more control of your health. Studies show that fully open communication with your doctor or nurse benefits you and your care partners. And we can help you find your notes.</p> <p><a href="#">Read More</a></p>	 <p><b>Patient Safety Movement Foundation</b></p> <p>The Patient Safety Movement Foundation was founded in 2002 and became a 501(c)(3) in 2014.</p> <p>We connect the dots between all stakeholders working to advance patient safety by challenging the status quo and breaking down silos.</p> <p><a href="#">Read More</a></p>	 <p><b>Pittsburgh Regional Health Initiative</b></p> <p>The Pittsburgh Regional Health Initiative (PHI) is one of the nation's first regional collaborations of medical, business, and civic leaders organized to address healthcare safety and quality improvements.</p> <p><a href="#">Read More</a></p>
 <p><b>PROJECT PATIENT CARE</b></p> <p>Engage consumers as partners in healthcare and make life easier. Healthcare stakeholders to provide the best possible care to every person every time, by eliminating preventable harm and implementing systemic change to ensure consistent excellence.</p> <p><a href="#">Read More</a></p>	 <p><b>SAFE CARE CAMPAIGN</b></p> <p>Safe Care Campaign is an organization dedicated to working diligently on early prevention and detection of all types of infections, whether they occur in a health care setting, in the community or at home.</p> <p><a href="#">Read More</a></p>	 <p><b>Yee And Leadership</b></p> <p>Yee And Leadership principals have extensive experience in generating bottom-line results that make a difference – across many challenging sectors and issue areas.</p> <p><a href="#">Read More</a></p>	 <p><b>Hong Tai Patient Safety, Air Quality</b></p> <p><a href="#">Read More</a></p>





## 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](http://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://empathicinterview.com/empathic-interview/>

# 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

Code of silence for mistakes

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Problems with the med system don't ever seem to get fixed

### Mistakes

### Truth

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

### System

Nurses are going to leave because of this

The hospital should be prosecuted

In healthcare, the little people always get screwed

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### Nurse



# David's Video on New Agreements Model Applied

## 3D: Discovery, Distillation, Defining

Code of silence for mistakes

We can't admit errors

Hospital won't admit errors

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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

### Mistakes

## 2. Truth

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.

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## 1. System

## 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