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Reaching resolution after patient harm

Chronology of the Vanderbilt Nurse Case

Synthesized from the following Tennessean newspaper article:
https://www.tennessean.com/story/news/health/2020/03/03/vanderbilt-nurse-radonda-vaught-arrested-reckless-homicide-vecuronium-error/4826562002/

12-24-2017	Patient Ms. Charlene Murphy is admitted to Vanderbilt with a subdural hematoma.
12-26-2017	Patient's condition improves and she is almost ready for discharge. During a final scan in the hospital's radiology department, patient is supposed to receive the sedative Versed but is accidentally given a dose of vecuronium, a paralyzing medication, according to federal investigators report. As a result, patient is brain dead.
12-27-2017	Patient dies after life-support is removed. Later that day, 2 Vanderbilt neurologists report her death to the Davidson County medical examiner without mentioning the medication error or the actual medication that was the paralytic that caused her hypoxic event. Based on information provided by Vanderbilt, the medical examiner did not independently investigate the death as it was deemed natural.
01-2018	In the wake of the patient's death, Vanderbilt officials take several actions that obscured the fatal medication error from the government and the public. The error was not reported to state or federal officials as required by law or to the Joint Commission, which is recommended but not required. Nurse Radonda Vaught is fired by Vanderbilt.
Early 2018 (date unknown)	Vanderbilt negotiated an out-of-court settlement with the family, including an industry-standard nondisclosure and confidentiality agreement. The settlement amount and terms are not known to the public.
05-2018	Nurse Vaught begins working as a coordinator at Tri-Star Centennial Medical Center in Nashville according to state records and her LinkedIn account. This is not a clinical position, but it does require a nursing license, records say.
10-03-2018	An anonymous tip alert state and federal health officials to the end reported medication error that was responsible for Ms. Murphy's death.

10-23-2018	The Tennessee Department of health, which is responsible for licensing investigating medical professionals, decides not to pursue disciplinary action against nurse Vaught. In a letter to Vanderbilt, the agency's investigations director says the nurse's case did not constitute a violation of the statutes and or rules governing the profession. On the same day, nurse Vaught is sent a letter saying this matter did not merit further action.
10-31-2018- 11-08-2018	In response to the anonymous tip, the Centers for Medicare and Medicaid Services (CMS) conducts a surprise inspection at Vanderbilt. The inspection confirms that Ms. Murphy died from an accidental dose of vecuronium. Vanderbilt did not report the medication error to the government or the medical examiner, according to an inspection report.
11-2018	The circumstances of the fatal medication error become public for the first time. CMS releases an investigation report that details the error without identifying the nurse or patient Murphy. CMS threatens to suspend Vanderbilt's Medicare payments, crippling the hospital's revenue, if Vanderbilt cannot prove it has taken steps to prevent a similar error. Vanderbilt quickly responds with a plan of correction that appeases the federal agency and secures its Medicare reimbursements. Vanderbilt declines to release the plan correction, although the Tennessean newspaper later obtains it through a public records request.
02-04-2019	Nurse Vaught is publicly identified for first time when arrested on a criminal indictment for her role in Ms. Murphy's death. She is charged with reckless homicide and impaired adult abuse. Court documents also reveal Ms. Murphy's identity for the first time. In an interview with the Tennessean, Ms. Murphy's family members say she would forgive nurse Vaught.
02-05-2019	Vanderbilt executives speak about the fatal error during a meeting of the Tennessee Board of Licensing Healthcare Facilities, which is responsible for disciplining hospitals. Vanderbilt's CEO admits the death wasn't reported to state regulators and said the hospital's response was "too limited". Vanderbilt officials also confirmed for the first time that they negotiated a settlement with Ms. Murphy's family. The board takes no disciplinary action against Vanderbilt.
02-08-2019	In a GoFundMe post to raise money for her legal of defense, the nurse appears to admit she made a mistake but does not elaborate. "Mainly feel very strongly that setting the precedent that nurses should be indicted and incarcerated for inadvertent medical errors is dangerous," she wrote.
02-20-2019	Nurse Vaught makes her first court appearance in her criminal case and enters a not guilty plea to all charges.

03-27-2019	In court records, prosecutors reveal far more details about the nurse's criminal case. Investigators allege that the nurse made 10 separate errors when giving the wrong medication to Ms. Murphy, including overlooking multiple warning signs that she had the wrong medication. Court records state that the nurse would had to have looked directly at a warning stating "warning: paralyzing agent" before injecting the drug. Court documents also said that the nurse admitted her mistake to investigators.
08-20-2019	At the request of law enforcement, the Nashville medical examiner re-examined the circumstances of Ms. Murphy's death. Now aware of the medication error, the official manner of death is changed to "accidental".
09-27-2019	The Tennessee Department of Health reverses its prior decision not to pursue professional discipline against nurse Vaught. Instead, the agency charged Vaught with three infractions. The agency refused to explain why it reversed its prior decision.
Late 10-2019 to mid-11-2019	Because nurse Vaught is now facing to legal proceedings, a criminal trial, and a professional discipline hearing, a debate begins over which case should proceed first. Ms. Vaught's attorney attempts to delay the discipline proceeding until after her criminal trial, arguing that as she defends herself by testifying in the discipline hearings prosecutors may use that information against her at trial. However, attorneys for the Health Department oppose this delay, insisting it's an urgent threat to the public. An administrative judge decides not to delay the proceedings, saying Ms. Vaught's desire to delay the hearing is outweighed by the seriousness of the allegations against her.
12-15-2019	The Tennessean newspaper publishes a story detailing the actions taken by Vanderbilt, and allegations are made of a cover-up.
Spring 2020	Covid pandemic delays both the professional discipline hearing and the criminal trial.
07-22-2021	Ms. Vaught's medical disciplinary hearing finally begins. During testimony, she did not shirk responsibility for the patient's death accepting complete responsibility in fault. She and her attorney also argued the mistake was made possible because of flawed procedures at Vanderbilt. At the time they said Vanderbilt was struggling with a problem that prevented communication between electronic health records and medication cabinets in the hospital pharmacy. They said this was causing delays at accessing medications, and the hospital's short-

term work around was to override the safeguards on the cabinets so they could get drugs quickly as needed. “Overriding was something we did as a part of our practice every day,” she testified. “You couldn’t get a bag of fluids for a patient without using an override function.”

07-23-2021 The Tennessee Board of Nursing revokes Ms. Vaught’s nursing license.

03-21-2022 The criminal trial begins with jury selection.

03-25-2022 The trial ends with the jury finding Ms. Vaught guilty of criminally negligent homicide and gross neglect of an impaired adult.

05-13-2022 Nurse Vaught is sentenced to three years’ probation.