Guest Editorial

A Step Forward or Backward for Nurses and Patient Safety?

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March 25, 2022, is a day the nursing profession will remember for decades to come. Social media feeds lit up when a criminal verdict for a medication error was released against one of nursing's own, RaDonda Vaught. Members of our profession continue to struggle to understand Vaught's experience, and the question remains: "What is the lasting impact for both nursing and patient safety?"

Before the Institute of Medicine's *To Err Is Human* report was released in 2000, health care errors were often ignored or brushed under the rug.[1] This silence regarding health care errors was primarily driven by the punitive way errors were handled. The individual caregiver was blamed for the error as they were the last person with the patient before the error occurred. Contributing factors, processes, and others involved were not considered.

I recall struggling with this blame in my first position as a nurse manager. I lost sleep when a nurse came forward to say "I made a medical error." I understood how system issues often contributed to the error, yet I was held accountable for "scoring" the error; the more points, the more severe the punishment. As a result, the punitive system that held the nurse singularly accountable led to silent nurses and silent managers. The silence resulted in recurring errors and a lack of safety for those who were most vulnerable, our patients.

After the publication of *To Err Is Human,* there was a shift in health care from a single-minded focus on individuals to a consideration of the system as accountable for errors.[1] Dr James Reason investigated the complex systems and processes that, when aligned, resulted in errors by well-intentioned clinicians, calling this system approach the "Swiss Cheese" model.[2] In the model, each slice of cheese represents actions taken to reduce risk. The holes represent limitations where failure can occur. Stacked together, the slices of cheese represent how an entire organization attempts to mitigate risk. Because the holes have different sizes and positions, an error only happens when holes line up and go through the entire stack. The Swiss Cheese model shows that errors usually are caused by more than 1 factor and cannot be traced to a single root cause or individual. The model has taught leaders to look at all processes, because usually more than 1 process failed by the time an error reached the patient.[2-4]

The groundbreaking work of the Swiss Cheese model overlooked a key aspect of patient safety: individual accountability. Most clinicians do not behave recklessly; they are not under the influence of mind-altering substances, nor do they intentionally ignore safety protocols. However, some clinicians need to be held accountable for their behavioral choices. Examples of behavioral choices that do not support safety and are considered reckless

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include caring for patients while under the influence of mind-altering substances or intentionally ignoring safety features. How do we balance systems and individual accountability? We create and foster a Just Culture. The concept of a Just Culture provides a framework for health care leaders to analyze system processes and individual behavioral choices to determine how to prevent errors in the future. The literature clearly documents that system failures, not the behavior choices of an individual, lead to most errors.[5-7]

A caregiver who practices with impaired judgment or malicious actions, or behaves in a reckless manner, must be held accountable. Accountability may include retraining, coaching, or progressive discipline. In the same way an individual's behavioral choices must be reviewed, a system's role also must be reviewed. The system may have outdated policies and procedures, malfunctioning equipment or supplies, or a lack of optimized electronic health records. Steps must be taken to correct or mitigate these system issues to prevent similar failures in the future.[5-7]

A major reason why Just Culture has changed the landscape of health care errors is that it encourages caregivers to report all near misses and actual errors. Near misses and errors become learning opportunities; opportunities to improve system processes and prevent future errors.[5-8] Transparent communication of errors facilitates health care system changes, leading to tremendous improvements for patients. Medication and laboratory barcode scanning, patient identification, electronic records, reduced distractions, and independent double checks are examples of changes that have resulted in safer patient care through reporting of errors. These improvements have also given nurses confidence that the system has adequate controls, checks, and balances in place to ensure the safest outcomes possible. Reporting errors is an important part of these improvements. For example, if the number of times a wrong medication was given to the wrong patient had not been reported, there might not have been a push to install expensive complex barcode scanning systems.

Everything changed on March 25, 2022. Nurses across the United States were shocked, dismayed, and even terrified when the Nashville District Attorney pressed charged against Vaught and a jury found her guilty of criminally negligent homicide and abuse of an impaired adult. Nurses' bold voices cried out in support of Vaught. Concerned for her well-being, for nurses who might make an error in the future, and for the safety of patients, some nurses declared they would no longer report errors, afraid they would experience the same fate.

Vaught accepted full responsibility for the lapses in safety protocols contributing to the error and was held accountable by her employer. Vaught testified she did not have malicious intent when she skipped the protocols. Reports confirm she was not impaired. She was held accountable by being reported to the Tennessee Board of Nursing, losing her job, and subsequently losing her license.[9] But why did the story not end there? Why did the Nashville District Attorney press criminal charges?

When details of this event were made public, some health care systems began to examine whether a similar error could occur in their facilities. The overwhelming answer was yes.[10-13] In organizations across the United States, teams of caregivers in the fields of patient safety, pharmacy, physicians, and nursing came together and changed hospital processes to correct each human and process error that transpired within the Swiss Cheese model of errors.[10-13] Changes were made to restrict access to paralytic agents, reduce the ability to override taking medications from electronic dispensing cabinets, enhance labeling of high-risk medications, and align data transfer between the electronic record and the dispensing cabinet.[10-13] Caregivers were educated about key safety principles, such as distractions and safely overriding medications. Some health care systems took responsibility to ensure the safety of patients and to protect nurses across health care systems from making a similar error.[10-13] In the absence of reporting, this error could have happened with another patient, but instead Ms Vaught's professional accountability prevented similar occurrences in other hospitals.

Was the nurse negligent? Given the system issues that were identified in the Vaught case, opinions vary on whether a reasonably prudent nurse would have acted as Vaught did. However, many experts agree her actions did not demonstrate malicious intent. Instead, nurses must continue to use their bold voices to educate both the public and the legal profession that criminalization of health care errors is not the solution.

To protect both nurses and the public, it is critical to advocate for a Just Culture approach. A Just Culture relies on reporting near misses and errors when they occur. In a Just Culture, the individual and the system

hold commensurate accountability for process changes and continuous learning to prevent errors from occurring. Nurses are individually accountable for our behavioral choices, but criminalization of health care errors has no role without evidence of malicious actions or intent. Criminalization of errors will take us back to a culture of silence and a lack of safety for nurses and patients. CCN

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