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What a case like this should do for us...

Many nurses have inquired about the recent RaDonda Vaught case, where a nurse, following a medication error in late 2017, was convicted by a jury of negligent homicide and gross neglect of an impaired adult.

First and foremost, the Montana Nurses Association extends our deepest sympathies to the family who has suffered this loss, furthermore, we extend our sympathies to all the families impacted by this tragedy.

What a case like this should do for all of us is give us pause to reflect on our own practices, reflect on how we adhere to safe medication administration practices ourselves, and what do we do to maintain safe practice?

A difficult but very necessary part of providing care means disclosing errors when they occur and MNA is concerned that nurses may now feel intimidated or fearful about divulging mistakes in their reporting and documentation.

Nurses need to continue to report through your institutions' processes, policies, and procedures any errors or safety incidents that deviate from safe practice or any "near misses" to be proactive. This allows these incidents to be thoroughly investigated adhering to the organization's values, mission, integrity, and commitment to all affected.

Nurses are taught medication administration rights, and many situations (flawed systems, cultures of fear, lack of accountability etc...) can contribute to a deviation from safe practice and policy. Perhaps most of these are small deviations, however, the consequences or outcomes can range from little to no effect, up to the most devastating effect, a patient's death.

Safety, and a Just, fair, and open Culture is within each of us, within the unit or department, and the organization as a whole, including all the healthcare and supportive staff. Shared accountability, collaboration, and transparency are critical to create a learning culture, designing safe systems, and managing behavioral choices.

MNA supports the implementation of safety systems to foster reporting, learning and a culture of trust. These systems should include the development of processes that support the improvement of patient care. This includes the involvement of direct care nurses at all levels to be a part of the development of system changes that enhance the quality of patient care across the continuum.

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