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Argument stance: (RaDonda Vaught) Nurse is at fault

Thesis Statement (for 3/29 class): Although the work of nurses can be long, RaDonda is at fault for the death of the patient, as she ignored the override warning generated by the hospital system, ignored the clear warning label of the paralyzing agent, and failed to follow the hospital's proper protocol. (dionisia)

Rebuttal

1. **To blame the healthcare system establishes a precedent that encourages the denial of personal responsibility. If blaming the healthcare system is a viable defense strategy then the legal repercussions of such reckless error become obsolete. The consequence of established laws is what prevents people from committing crimes and making mistakes. To remove consequences would permit an increase in the incidence of similar neglect of proper patient care. (dionisia)**

Main points of argument:

1. She had the opportunity to double check the medication she chose yet still overrode the decision, saying it was a "normal part of the day". The override option gave her an opportunity to make sure it was the right medication, so overriding was neglect and a sign that she was not doing her job correctly.

2. She only typed the first few letters of the medication instead of the entire name which led to the switch up (due to the medicines having the same first letters). In addition to that, versed has a common name- midazolam- that she should have typed in, instead to yield the correct result.

3. The medicine had a warning on the cap that clearly showed that the medicine was a paralyzing agent, which she missed on 3 separate times. This was a label that was noticeable, which means she was negligent.

4. She did not follow the hospital's proper protocol for administering medication, she was careless and failed to double check. She deliberately opposed the hospital's pre-established instructions that she was aware of.

5. Though she appears to have had no intention to kill the patient, her lack of attention to distinguish between a dangerous medicine and the intended drug shows that she exhibited harmful behaviors.

6. In any job, you get fired if you make a major error, so the hospital isn't an exception to normal job consequences

7. She has been trained for years to deal with high-stress medical environments, so to blame the system for a lack of retaining your medical education is obstructive.
    a. She worked as a neurointensive ICU nurse, which means that she should have been prepared for the workload, so being negligent is her fault.
    b. According to the American Nurses Association's, nurses are both "accountable and responsible for the quality of their practice."
    c. This issue was not a problem for her in the 14 years that she had been working as a nurse, so this issue is due to her negligence as opposed to that of the hospital.

8. Usually the drug and the patient's wristband is scanned before administering the drug, which she failed to do

9. Even if the system used by the hospital contributed to the incident, the nurse is the individual who carried out the action that killed the patient.
    a. Several of the procedures used by the hospital would have stopped this incident (having another nurse check, monitoring vitals)

10. Legally speaking, the hospital is covered in terms of its practices, which adds blame to the nurse, who broke these practices.

11. Even though she did not intend to do any harm she acted unreasonably with disregard to the consequences.

Potential sources:
(We could probably compare this profession to another one that involves assisting the public and show that her actions aren't excusable) Yeahh, we can say that even though they wouldn't have criminal charges pressed, they're still liable for the murder? Like that would still reflect on them as a professional.
We can do the police force when they are training a rookie?
If a pilot crashes a plane while training someone they are still fired for endangering lives, proving they were not capable at their job.
Wasn't she the one training someone ? yeah she said she got distracted from the trainee which is why she didn't read the label right

myamericannurse.com/promoting-professional-accountability-ownership/#:~:text=According%20to%20the%20American%20Nurses,only%20individually%20but%20also%20as :

- **According to the American Nurses Association's (ANA) Code of Ethics for Nurses with Interpretive Statements, nurses are both "accountable and responsible for the quality of their practice."**

https://journalofethics.ama-assn.org/article/why-accountability-sharing-health-care-organizational-cultures-means-patients-are-probably-safer/2020-09

- **"...the nurse's actions were indeed criminally reckless rather than merely erroneous. Her actions could be akin to those of a driver who is texting or speeding and strikes a passerby, killing him or her; both the driver's and the nurse's actions were choices rather than mere errors, and the consequences were foreseeable and preventable."**

https://www.virginiasinjurylawyers.com/faqs/what-are-the-4-ds-of-medical-negligence/

To prove medical negligence, we can use the four Ds of medical negligence. These four are duty of care, dereliction of duty, direct causation, and damages.

1. **Any medical professional who has anything to do with your treatment or diagnosis has a duty of care toward you. Radonah was the one in charge of administering medication to the patient so she had a direct duty of care with the patient.**
2. **Dereliction refers to a failure to fulfill one's duty of care. Radonah failed to administer the correct medication for her patient and failed to follow the proper protocol of administering medications.**
3. **Direct causation is when there is direct connection between dereliction of duty and any damage. Radonah's failure to administer the correct medication directly caused the patient's death.**
4. **Damages is any damage suffered as a result . The patient died as a result.**

This proves that Radonah was being neglectful, and her actions directly harmed the patient. Even though she did not intend to do any harm, she acted unreasonably with disregard to the consequences.

(can you please read this. thanks) highlight everything i should read and lmk when u want me to say it

https://news.osu.edu/study-points-to-methods-for-safe-drug-dispensing-via-computer/

- Patients wear bar-coded wristbands. Nurses scan a patient's wristband, and a laptop computer on the medication cart displays that patient's prescriptions. Before giving the medicine, the nurse scans the medicine bottle or other container, and BCMA records the drug as delivered. If the nurse accidentally scans the wrong medicine or dosage, or tries to give medicine at the wrong time, a warning pops up on the computer screen.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4704040/

- Preventable medical errors (MEs) are a leading cause of medical injuries worldwide. The use of wristband bar-code medication scanning can reduce the ME around 57.5%. Since compliance with the bar code system has been very high with a low frequency of failure and it is accepted by the staff, it can be used in hospitals for improving the quality of services. Therefore if this technique is widely accepted, it should not be ignored and should be practiced with caution.

https://www.ismp.org/resources/safety-enhancements-every-hospital-must-consider-wake-another-tragic-neuromuscular

- While removing the vial from the ADC the nurse noticed that the medication was a powder and turned the vial over to read the reconstitution directions on the back of the label, never reading the actual drug name on the front of the vial label. She also did not recognize that Versed(the moderate sedation agent) is available only in a liquid injectable form, not a powder requiring reconstitution. This shows that this was more than a small mistake as this was a careless move which demonstrates poor knowledge worthy of a revoked license. These actions resulted in the death of a patient and were a clear violation of the duty of care that healthcare professionals owe to their patients.

https://www.myamericannurse.com/medication-errors-best-practices/#:~:text=Consequences%20for%20the%20nurse,possible%20civil%20or%20criminal%20charges.

- To promote administering medication safely, there is something called the "five rights" of medication administration: the right patient, the right drug, the right time, the right dose, and the right route. The nurse managed to complete none of these recommendations when administering medication to a patient, as she did not properly identify her patient, she didn't administer the proper drug, she couldn't have administered the drug in the right time as it was the wrong medication, she did not provide the right dosage, and most importantly, she did not stay and monitor the reaction of the medication on the patient. By not following any of these recommendations when administering medication, the nurse instantly put herself in the way of liability, and negatively impacted the health of a patient.

https://www.nursingprocess.org/negligence-in-nursing-examples.html

- There are four elements of negligence in nursing that are covered in this article. Nurses must behave within their scope of practice, but Vaught was distracted with training

someone else. As a nurse, she should have been aware of the scope of her abilities. Her job is to verify the medication for accuracy.

https://www.maine-personal-injury-lawyers.com/why-the-nurse-gave-the-medication-that-killed/#:~:text=Another%20medication%20that%20starts%20with,not%20the%20same%20as%20Versed.

Introduces the fact that the computer system allows for a nurse to type in the abbreviated name but also the common name. Even while typing the abbreviated name and pressing the override, the entire name of the medicines pops up.Versed and Vecurondium have the same “VE” however the common names are different. Versed’s common name is midazolam, which definitely was listed. In addition, upon receiving the medication, she failed to look at the warning label.

1. Radonda Vaught took the wrong drug out of the ADC Medicine Cabinet.
2. She did not properly search for the correct drug in the ADC Medicine Cabinet.
3. She overrode the computer.
4. She failed to verify with the pharmacy.
5. She failed to type in the correct name of the medication.
6. She neglected to read the computer screen.
7. She withdrew the drug from the pocket drawer, disregarding the sticker that read **“Warning: Paralyzing Agent”**
8. She never visually checked the medication.
9. She did not ask a second nurse to check the medication.
10. She did not properly identify her patient.
11. She did not scan the drug and the patient wristband prior to giving her patient the drug.
12. She did not check the drug name on the vial.
13. She reconstituted the drug.
14. She ignored **“Warning: Paralyzing Agent”** on the vial top 3 times:
    1. When swabbed with alcohol;
    2. When introduced saline for reconstitution with a syringe through the top; and
    3. When she withdrew the medication drug with a syringe through the top
15. She did not check her patient’s vitals before giving the drug.
16. She did not monitor patient reaction to drug.
17. She did not monitor patient vital signs after administering the drug (had she just done this, she would have realized her errors and could have saved Charlene Murphey’s life).
18. After administering the paralyzing drug, Radonda Vaught left her patient Charlene Murphey.