Institute for Safe Medication Practices
200 Lakeside Drive, Suite 200, Horsham, PA 19044
www.ismp.org

FOR IMMEDIATE RELEASE
2/13/19

CONTACT: Renee Brehio, Media Relations, ISMP
614-376-0212, rbrehio@ismp.org

ISMP Calls for a System-Based Response to Errors, Not Criminal Prosecution

Healthcare Leaders Urged to Avoid Severity Bias, Establish Just Culture

Horsham, Pa.—In the wake of recent criminal charges being filed against a registered nurse in Tennessee who was involved in a fatal medication error, the Institute for Safe Medication Practices (ISMP) is emphasizing that the focus should be on identifying and fixing imperfect systems instead of unjustly blaming the individual healthcare practitioner. The cover article in this week's issue of the ISMP Medication *Safety Alert!*® newsletter outlines ISMP's position on the nurse's indictment and the criminalization of medical errors.

The nurse has been charged with reckless homicide and abuse of an impaired adult more than a year after inadvertently administering a medication that caused the patient to stop breathing (neuromuscular blocking agent vecuronium) in place of VERSED (midazolam), a medication prescribed to help with her anxiety before a radiology scan. Unable to find Versed on the patient's profile in an automated dispensing cabinet (ADC), a type of technology currently being used for medication distribution in the majority of U.S. hospitals and health systems, she enabled the override function, entered "VE" into the search field, and erroneously selected vecuronium.

Medication errors are tragic and heartbreaking events for everyone involved, but criminal prosecution can undermine the creation of a culture of safety and error reporting and reduce the healthcare community's ability to learn from mistakes and prevent future tragedies. The newsletter article's key points include that ISMP:

- Supports the nurse as a "second victim" of a harmful error.
- Does not believe that criminal charges are justified in this case.
- Does not believe that criminal prosecution will result in overall safety improvements.
- Urges healthcare leaders to be accountable for safe system design.
- Promotes avoiding "severity bias" (reacting to the severity of the harm instead of the quality of behavior choices when deciding accountability) and establishing a Just Culture.

ISMP is deeply concerned about the criminalization of human error even in the absence of any intent to cause harm, as has apparently occurred in this case. According to the local District Attorney's Office, the nurse's decision to obtain the medication via override was central to the criminal indictment. However, the override feature is available for good reason in basically every hospital with ADCs, and this function is used every day by healthcare practitioners to obtain medications when a delay would impact patient care. This mistake could have happened in many other hospitals due to common, underlying system vulnerabilities that need to be addressed.

ISMP has just published updated guidelines for safe use of ADC cabinets that can help healthcare organizations adopt standard practices and processes and optimize patient outcomes. For a copy of the guidelines, which address overrides, visit: https://www.ismp.org/resources/guidelines-safe-use-automated-dispensing-cabinets.

In addition, ISMP has provided strategies for safe prescribing, storage, selection, preparation, and administration of neuromuscular blockers such as vecuronium in a June 16, 2016 newsletter article: https://www.ismp.org/resources/paralyzed-mistakes-reassess-safety-neuromuscular-blockers-your-facility

For a copy of the full article on criminalization of medication errors and the potential impact on patient safety, visit: https://www.ismp.org/acute-care/medication-safety-alert-february-14-2019.

About ISMP: The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit charitable organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. In 2019, ISMP is celebrating its 25th anniversary of helping healthcare practitioners keep patients safe and leading efforts to improve the medication use process. For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit www.ismp.org.

-end-