Issue: Group III Written Notice with Termination (client abuse); Hearing Date: 05/16/17; Decision Issued: 05/31/17; Agency: DBHDS; AHO: Jane E. Schroeder, Esq.; Case No. 11013; Outcome: No Relief – Agency Upheld; **Administrative Review Ruling Request received 06/14/17; EDR Ruling No. 2017-4570 issued 06/29/17; Outcome: AHO's decision affirmed.**

COMMONWEALTH OF VIRGINIA

Department of Human Resource Management
Office of Employment Dispute Resolution

DECISION OF THE HEARING OFFICER

In the matter of Case #11013

Case Heard: May 16, 2017
Decision Issued: May 31, 2017

PROCEDURAL HISTORY

The Grievant was employed by the Agency. On March 27, 2017, the Agency issued a Group III Written Notice to the Grievant for patient abuse. The Grievant was terminated. The Grievant filed a Grievance on April 7, 2017. The relief requested by the Grievant was reinstatement to his employment with back pay and removal of record of termination from files.

The case was heard on May 16, 2017, beginning at 9:00 a.m., and concluding at 2:55 p.m. The Grievant appeared and was represented by an attorney. An advocate appeared for the Agency. Grievant's Exhibits pages 1-38 were entered into evidence without objection.

At the onset of the hearing, the Grievant's attorney submitted a "Motion in Limine and Objection to Proposed Exhibits." In that pleading the Grievant objected to the introduction of the video and any exhibits or testimony derived from the video, since the video was not provided to the Grievant's attorney one week before the hearing. Please see the attached order denying this motion and overruling the objection to the exhibits. Agency's Exhibits A-J were entered into evidence.

Three witnesses for the Agency and two witnesses for the Grievant testified. The hearing was recorded on a digital recorder and stored on a compact disk.

APPEARANCES

Grievant
Attorney for the Grievant
Advocate for the Agency

Witnesses for Agency:	1.	Abuse & Neglect Investigator
	2.	Director of Training
	3.	Chief Nurse Executive
Witnesses for Grievant:	1.	Grievant
	2.	Registered Nurse

ISSUE

Whether the Group III Written Notice Issued to the Grievant on March 27, 2017 and subsequent termination should be sustained, modified or revoked.

BURDEN OF PROOF

In disciplinary actions, the agency must present its evidence first and the burden of proof is on the Agency to show by a preponderance of the evidence that its action against the Grievant was warranted and appropriate under the circumstances. A preponderance of the evidence is evidence which shows that what is sought to be proved is more probable than not. (Grievance Procedure Manual). This case is a disciplinary action. In this case, the agency must prove that it is more likely than not that the Grievant physically abused a patient. The agency must prove that issuing a Group III Written Notice and termination of the Grievant was warranted and appropriate.

FINDINGS OF FACT

1. The Grievant was employed by the Agency for 19 years. In his position as Psychiatric Technician II, he was responsible to "facilitate individual and group programs through planned, spontaneous, structured and unstructured activities that are provided consistent with overall active treatment programming as well as consistent with the individual patient's comprehensive treatment plan and nursing care plan…. The position functions under the supervision of a registered nurse."[1]

2. In his last performance evaluation, on October 20, 2016, he was rated as Extraordinary Contributor in four of five Core Responsibilities, with an overall rating of Extraordinary Contributor.[2] At that time, he was also given a Performance Management Acknowledgement of Extraordinary Contribution and was cited for "the extraordinary contributions he has made to the Nursing Department and the institution as a whole. His leadership skills and insight has fostered an environment where creativity and teamwork were valued in providing exceptional care to individuals requiring extensive assistance such as dementia and individuals with memory loss. He is also commended for having positive attitude and always willing to offer assistance and support when needed in dealing with difficult individuals."[3]

3. On February 4, 2017, two patients (one male, one female) in the unit where the Grievant worked were involved in several incidents around 6:30 p.m. A Register Nurse who had witnessed the male patient in previous incidents at the facility described that patient as low functioning, very volatile, who would hit someone without warning. Because of his low

[1] Grievant Exhibit page 19: Employee Work Profile
[2] Grievant Exhibit, pages 13-16.
[3] Grievant Exhibit, page 17.

functioning, verbal intervention often did not work. The Grievant testified that that patient would throw himself on the floor when the he was upset and would bang his head on the floor.[4]

4. On February 4th, the male patient had been in physical restraints earlier in the day. He was released from physical restraints some time prior to 4:00 p.m. The Grievant testified that the male patient started having behavior problems that day between 4:30 and 5:00. The Grievant intervened in an incident where the male patient was standing too close to another patient, and grabbed a paper from that patient. The other patient hit the male patient. The Grievant was able to remove the male patient from the room and tell him to stay away from that other patient.[5]

5. Around 6:25p.m., the male patient went up to the female patient who was standing at the chart room door and slid his foot into the female patient's foot. She slapped the male patient. A nurse spoke to the male patient. Then, the female patient was talking on the hall phone when the male patient approached her and grabbed a paper in her hand. The female patient hit him as he backed away. Three staff: the Grievant, another Psych Tech, and a nurse, responded to the incident and the staff discussed the situation.[6]

6. Around 6:35 p.m., the male patient approached the female patient again while she was on the phone. The Grievant intervened, redirecting the male patient by placing his hand on the male patient's face and directing him to turn. The male patient pulled the hair of the female patient. The Grievant then pushed the male patient away and guided him down the hall to the ante room. The female patient followed them to the ante room, slapped the male patient and spit toward the male patient, who was being held against the wall by the Grievant. After the female patient left the ante room, the Grievant asked a staff member to open the seclusion room. When the room was opened, the Grievant pushed the male patient into the room. The male patient resisted, and at one point spit toward the Grievant. The Grievant then pushed the male patient into the seclusion room forcefully enough that the patient landed on his knees on the mat six feet away.[7]

7. The Grievant wrote and submitted a Facility Event Report for each of the patients involved. In the male patient's Report, the Grievant categorized the event as an aggressive act against another patient and described the event as follows: "While pt. [#] was on the phone, he went to her and snatched her papers from her." He described the treatment/interventions as follows: "Pt. teaching was provided and he was receptive to it." In the female patient's report, the Grievant categorized the event as an aggressive act against another patient and described the event as follows: "Pt. [#] snatched papers from her while she was on the phone. She went after him and slapped him on the left side of his face." He described the treatment/interventions as

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[4] Testimony of Registered Nurse and Grievant

[5] Testimony of Grievant.

[6] Testimony of Grievant, Testimony of Investigator, Agency Exhibit C, page 4.

[7] Agency Exhibit J: videotapes; Agency Exhibit C, pages 4-5.

NOTE: This incident was videotaped on three security cameras at the facility. These videos, which had no audio, were replayed at the hearing for the witnesses by the Agency and the Grievant.

follows: "Pt. teaching was provided."[8]

8. The Grievant testified that he would not use the word, "push" to describe his actions. He testified that, "I was helping him move on." The Grievant denied using force to push the male patient into the seclusion room. In fact, he said that the patient threw himself on the floor. The Grievant testified that he thought his own actions were appropriate.[9]

9. In a letter dated February 16, 2017, from the Facility Directory, the Grievant was informed that he had been identified in an allegation of physical abuse from the events on February 4, 2017.[10]

10. An Abuse & Neglect Investigator from the Agency was assigned to the case. As part of her investigation, she interviewed the Grievant and other staff, watched the video from the security cameras, and reviewed written reports and statements. In the investigator's report, dated March 1, 2017, the conclusion of the investigator was that the Grievant pushed the male patient several times, and that the allegation of physical abuse was substantiated, in violation of the zero tolerance policy of the Agency as outlined in Departmental Instruction 201(RTS).[11]

11. On October 21, 2016, the Grievant signed a Statement of Commitment to the Agency's Zero Tolerance for Acts of Abuse & Neglect and to the Agency's Instruction 201(RTS) concerning Reporting and Investigating Abuse and Neglect.[12]

12. The Grievant, along with other therapeutic staff at the Agency, was trained to use approved techniques for behavior interaction and management. Under the program, Therapeutic Options of Virginia ("TOVA"), staff learns ways to handle aggression and avoid violence. The program also teaches certain physical restraints, such as the Transport Restraint and Side Body Restraint, to be used when necessary.[13] The Grieviant was TOVA trained, and completed the last annual recertification in TOVA in October, 2016.[14]

13. The Director of Training for the Agency testified that she provides the TOVA training and annual retraining for the Agency. In reviewing the video, she testified that the Grievant did not use proper TOVA techniques when he pushed the patient. The Grievant should have called for staff and used an approved transport or side body restraint to move the male patient away from the female patient. To alert staff that assistance is needed, the Grievant could yell, "Staff!," could push a blue button on the wall which would alert staff, or could ask another staff member

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[8] Agency Exhibit C, pages 10-11.
[9] Testimony of Grievant
[10] Agency Exhibit C, page 1.
[11] Agency Exhibits C & D, Testimony of Abuse & Neglect Investigator
[12] Agency Exhibit F, page 13.
[13] Agency Exhibit I.
[14] Agency Exhibit G.

to press the blue button.[15]

14. The Grievant testified that he did not call for staff or push the blue button or ask anyone to press the blue button because "it all happened so fast." When he approached the male patient, the Grievant did not try to use the TOVA restraint techniques because he did not think that would work.[16]

15. The Chief Nurse Executive[17] testified that she viewed the video after the investigation had begun as part of her role as overseeing the care of patients in the facility. She testified that she had known the Grievant when she had worked at this facility as nurse fifteen years ago. She thought highly of him and his interactions with patients. When asked whether, in her opinion, the actions of the Grievant pushing the male patient would rise to the level of abuse, she answered, "Unfortunately, yes."[18]

16. A retired Registered Nurse testified on behalf of the Grievant. She had known the Grievant for seventeen years. She testified that the Grievant was a very honorable individual who did not get angry or retaliate after being kicked or spit on by the patients. She was unaware of the circumstances that lead to the termination of the Grievant. When asked how a staff member should separate two battling patients, she stated that the staff member should first try to talk to one patient and convince the patient to move away from the area. If that is unsuccessful, the staff member should call for staff to assist in a body hold in moving one patient away. When asked if pushing the patient away from the other patient would be appropriate, she replied that pushing the patient would be abuse.[19]

17. On March 27, 2017, the Director issued a Group III Written Notice to the Grievant for Offense Code 81: Patient abuse. Under Section 2—Offense, the nature of the offense was stated as follows: "Group III Written Notice issued for a substantiated finding (Case #728-2017-0035) as evidenced by the event which occurred on February 4, 2017: physical abuse during a patient interaction. This disciplinary action is in accordance with DHRM Policy 1.60 Standards of Conduct." Under Section 3—Disciplinary Action taken, the disciplinary action taken was Termination, effective March 27, 2017.[20]

18. In the Group III Written Notice, under Section 4—Circumstances considered, the Director stated, "A thorough review was conducted of the supervisory file, personnel file and the

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[15] Testimony of Director of Training

[16] Testimony of Grievant.

[17] NOTE: Prior to the testimony of this witness, the Hearing Officer disclosed that she had met the witness several years prior when the Hearing Officer was a Special Justice in another facility. No objection was noted by either party to the witness testifying.

[18] Testimony of Chief Nurse Executive.

[19] Testimony of Registered Nurse.

[20] Agency Exhibit A

mitigating statement provided on 03/07/2017. After careful consideration, management will move forward with issuing the Group III Written Notice with termination."[21]

19. On April 7, 2017, the Grievant filed Dismissal Grievance Form A.[22] A hearing was scheduled at a pre-hearing conference, and the hearing was conducted on May 16, 2017 to determine whether the Group III Written Notice and the termination should be sustained, modified or revoked

20. **APPLICABLE LAW AND OPINION**

Departmental Instruction 201(RTS) entitled "Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities." outlines the Agency's policy of zero tolerance for abuse and neglect of individuals receiving services. The definition of abuse is "any act or failure to act by an employee or other person responsible for the care of an individual in a Department facility that was performed or was failed to be performed knowingly, recklessly or intentionally, and that caused or might have caused physical or psychological harm, injury or death to a person receiving care or treatment for mental illness, mental retardation or substance abuse.[23]

The Grievant was trained in the TOVA techniques for the proper ways to deal with patient aggression. He chose not to ask for staff to assist in dealing with the male patient. The Grievant was aware of the zero tolerance policy for abuse.

One example of abuse included in the DI 201(RTS) is "Use of excessive force when placing a person in physical or mechanical restraint." In this case the Grievant used force when placing the male patient in physical restraint. When removing the male patient from the hallway, he pushed the patient down the hallway, held him against the wall in the ante room, and then pushed him twice in the entrance to the seclusion room, once forcefully enough for the patient to fall across the room onto his knees.

The Grievant used excessive force in pushing the patient three times. These actions were performed intentionally. His intent was to separate two battling patients. The pushing did not result in physical injury. However, the action of forcefully pushing the patient down the hall and into the seclusion room might have caused physical or psychological harm to a patient receiving care in an Agency facility. Was the pushing abuse? I agree with witness that testified, "Unfortunately, yes." Even the nurse that testified on behalf of the Grievant stated that pushing a patient would be abuse.

The Virginia Personnel Act, VA Code ' 2.2-2900 et. seq., establishes the procedures and

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[21] Agency Exhibit A
[22] Agency Exhibit H
[23] Agency Exhibit D, page 1.

policies applicable to employment in Virginia It includes procedures for hiring, promoting, compensating, discharging and training state employees. It also provisions for a grievance 2-1201 and §53.1-102.procedure. The Act balances the need for orderly administration of state employment and personnel practices with the preservation of the employee=s ability to protect his rights and to pursue legitimate grievances. These dual goals reflect a valid government interest in and responsibility to its employees and workplace. Murray v. Stokes, 237 Va. 653,656 (1989).

The Operating Procedure, "*Standards of Conduct*," under Code of Virginia §2.2-1201 and §53.1, sets forth the Standards of Conduct and disciplinary process that the Agency must utilize to address unacceptable behavior, conduct, and related employment problems in the workplace or outside the workplace when the conduct impacts an employee's ability to do their job, or influences the agency's overall effectiveness.[24]

Standards of Conduct provides a set of rules governing the professional conduct and acceptable standards for work performance of employees. The Standards serve to establish a fair and objective process for correcting or treating unacceptable conduct or work performance, to distinguish between less serious and more serious actions of misconduct and to provide appropriate corrective action. Unacceptable behavior is divided into three groups, according to the severity of the behavior, with Group I being the least severe and Group III being the most severe.

Section 2.c. provides that Group III offenses include acts of misconduct of such a severe nature that a first occurrence normally should warrant termination. Attachment A outlines examples of Group III offenses. One of these examples is abuse or neglect of clients.

In the present case, the Grievant was issued a Group III Written Notice for physical abuse during patient contact for the events that occurred on February 4, 2017. Grievant was terminated.

In the Rules for Conducting Grievance Hearings, Section VI., Scope of Relief, B. Disciplinary Actions, section 1: Framework for Determining Whether Discipline was Warranted and Appropriate@ states as follows:

> The responsibility of the hearing officer is to determine whether the agency has proven by a preponderance of the evidence that the disciplinary action was warranted and appropriate under the circumstances. To do this, the hearing officer reviews the evidence de novo (afresh and independently, as if no determinations had yet been made) to determine (i) whether the employee engaged in the behavior described in the Written Notice; (ii) whether the behavior constituted misconduct; and (iii) whether the disciplinary action taken by the agency was consistent with the law (e.g., free of unlawful discrimination) and policy (e.g., properly characterized as a Group I, II, or III offense).[25]

[24] Agency Exhibit 3, p. 1, Agency Exhibit 4, p.1

[25] Rules for Conducting Grievance Hearings, VI.B1. Effective Date 7/1/2012.

Using this framework, this Hearing Officer will analyze this case.

(i) Whether the employee engaged in the behavior described in the Written Notice
The Grievant did physically abuse a patient on February 4 2017 when he forcefully pushed the patient three times. The employee engaged in the behavior described in the Written Notice.

(ii) Whether the behavior constituted misconduct
Based on the Agency's zero tolerance policy as outlined in Departmental Instruction 201(RTS), the Grievant physically abused a patient. This abuse was a violation of the Standards of Conduct. The Grievant's behavior constituted misconduct.

(iii) Whether the disciplinary action taken by the agency was consistent with the law and policy
The Standards of Conduct for the Agency lists patient abuse as a Group III offense. A Group III offense normally should warrant termination. The disciplinary action taken by the agency was termination. This is consistent with the law and policy.

Mitigating Circumstances
According to the Rules for Conducting Grievance Hearings, a hearing officer must give deference to the agency's consideration and assessment of any mitigating and aggravating circumstances. A hearing officer may mitigate the agency's discipline only if, under the record evidence, the agency's discipline exceeds the limits of reasonableness.[26] The Grievant in this case was a long-term employee with an excellent record. The Agency reviewed the personnel file and the mitigating statement provided by the Grievant. The Grievant was given a Group III Written Notice and was terminated. This Hearing Officer finds that the agency's discipline of imposing a Group III Written Notice and termination did not exceed the limits of reasonableness.

DECISION

The Group III Written Notice issued to the Grievant on March 27, 2017 is upheld. The disciplinary action of termination is upheld.

APPEAL RIGHTS

You may file an administrative review request within **15 calendar** days from the date the decision was issued, if any of the following apply:

1. If you believe the hearing decision is inconsistent with state policy or agency policy, you may request the Director of the Department of Human Resource Management to review the

[26] Rules for Conducting Grievance Hearings Section VI.B.2. p. 17

decision. You must state the specific policy and explain why you believe the decision is inconsistent with that policy. Please address your request to:

Director
Department of Human Resource Management
101 North 14th St., 12th Floor
Richmond, VA 23219

or, send by fax to (804) 371-7401, or e-mail.

2. If you believe that the hearing decision does not comply with the grievance procedure or if you have new evidence that could not have been discovered before the hearing, you may request that EDR review the decision. You must state the specific portion of the grievance procedure with which you believe the decision does not comply. Please address your request to:

Office of Employment Dispute Resolution
Department of Human Resource Management
101 North 14th St., 12th Floor
Richmond, VA 23219

or, send by e-mail to EDR@dhrm.virginia.gov, or by fax to (804) 786-1606.

You may request more than one type of review. Your request must be in writing and must be **received** by the reviewer within 15 calendar days of the date the decision was issued. You must provide a copy of all of your appeals to the other party, EDR, and the hearing officer. The hearing officer's **decision becomes final** when the 15-calendar day period has expired, or when requests for administrative review have been decided.

You may request a judicial review if you believe the decision is contradictory to law. You must file a notice of appeal with the clerk of the circuit court in the jurisdiction in which the grievance arose within **30 days** of the date when the decision becomes final.27

[See Sections 7.1 through 7.3 of the Grievance Procedure Manual for a more detailed explanation, or call EDR's toll-free Advice Line at 888-232-3842 to learn more about appeal rights from an EDR Consultant].

May 31, 2017

Jane E. Schroeder
Jane E. Schroeder, Hearing Officer

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27 Agencies must request and receive prior approval from EDR before filing a notice of appeal.