Issues: Step 3 Formal Performance Improvement Counseling Form with Suspension (failure to follow policy), and Step 4 Formal Performance Improvement Counseling Form with Termination (continued poor performance during performance warning period); Hearing Date: 08/01/18; Decision Issued: 08/21/18; Agency: UVA Medical Center; AHO: Carl Wilson Schmidt, Esq.; Case No. 11218, 11236; Outcome: No Relief – Agency Upheld; **Administrative Review Request received 08/30/19; EDR Ruling No. 2019-4773 issued 09/27/19; Outcome: AHO's decision affirmed.**

COMMONWEALTH of VIRGINIA

Department of Human Resource Management

OFFICE OF EQUAL EMPLOYMENT AND DISPUTE RESOLUTION

DECISION OF HEARING OFFICER

In re:

Case Number: 11218 / 11236

Hearing Date: August 1, 2018
Decision Issued: August 21, 2018

PROCEDURAL HISTORY

On March 15, 2018, Grievant was issued a Formal Performance Improvement Counseling Form, Step 3, with a performance warning for 90 calendar days. He received a 12 hour suspension. On May 1, 2018, Grievant was issued a Formal Performance Improvement Counseling Form, Step 4, with removal.

Grievant timely filed grievances to challenge the Agency's actions. The matter proceeded to hearing. On June 21, 2018, the Office of Equal Employment and Dispute Resolution assigned this appeal to the Hearing Officer. On August 1, 2018, a hearing was held at the Agency's office.

APPEARANCES

Grievant
Grievant's Counsel
Agency Party Designee
Agency's Counsel
Witnesses

ISSUES

1. Whether Grievant engaged in the behavior described in the Formal Performance Improvement Counseling Forms?

2. Whether the behavior constituted misconduct?

3. Whether the Agency's discipline was consistent with law (e.g., free of unlawful discrimination) and policy?

4. Whether there were mitigating circumstances justifying a reduction or removal of the disciplinary action, and if so, whether aggravating circumstances existed that would overcome the mitigating circumstances?

BURDEN OF PROOF

The burden of proof is on the Agency to show by a preponderance of the evidence that its disciplinary action against the Grievant was warranted and appropriate under the circumstances. The employee has the burden of raising and establishing any affirmative defenses to discipline and any evidence of mitigating circumstances related to discipline. Grievance Procedure Manual ("GPM") § 5.8. A preponderance of the evidence is evidence which shows that what is sought to be proved is more probable than not. GPM § 9.

FINDINGS OF FACT

After reviewing the evidence presented and observing the demeanor of each witness, the Hearing Officer makes the following findings of fact:

The University of Virginia Medical Center employed Grievant as a Respiratory Therapist. His Position Summary was:

> Responsible for collecting, interpreting and reviewing clinical data. Participates in the development of the plan of care and provides medically prescribed respiratory therapy services to Health System patients.[1]

Grievant had been employed by the Agency for approximately six years. He began working in the Unit in March 2015. Grievant worked from 7 p.m. until 7:30 a.m.

Grievant became a respiratory therapist because he wanted to do something challenging that affected people's lives in a positive and helpful way.

A catheter is a rubber tube with a curved tip. A trach tube is about 3.5 inches long and is inserted in the front of the patient's neck. To suction a patient, a respiratory therapist would insert a catheter tube into the patient's trach tube. The catheter should be inserted approximately five to six inches. Once the catheter tube was inserted, the

[1] Agency Exhibit 6.

respiratory therapist was to ask the patient to cough and then use the catheter tube to suction secretions from the patient's throat.

Suctioning can be an uncomfortable process for most patients, but it should not be consistently painful.

Deep suctioning occurs when, the catheter tube is inserted 10 to 12 inches into a lung. Deep suctioning can cause blood trauma and is painful for the patient. Deep suctioning of patients is not prohibited, but should be avoided by a respiratory therapist. Mr. H was an experienced respiratory therapist. He indicated he never deep suctioned. He said deep suctioning was frowned upon. Mr. T was an experienced respiratory therapist and he testified deep suctioning was not recommended. Mr. T testified a catheter would be inserted five to six inches at most. Mr. M was an experienced respiratory therapist who testified deep suctioning was frowned upon. He said deep suctioning was rare. Ms. B testified the catheter should not be inserted into a lung because it would be painful for the patient.

A patient would express pain through "body language" by grimacing or moving away from the respiratory therapist.

Patients in the Unit had serious medical conditions causing them to remain there for a month on average. They typically used ventilators and had to receive suctioning treatments from respiratory therapists. Patient W was ill from West Nile virus. She was quadriplegic and used a ventilator. Patient J was 25 years old and had been in an automobile accident. She was paraplegic and used a ventilator. Both patients received respiratory therapy from numerous respiratory therapists working in the Unit.

On March 1, 2018, Grievant provided treatment to Patient W. This treatment included deep suctioning.

Patient W told Mr. H that Grievant was rough with her and yelled at her. She was fearful of Grievant coming into her room to suction her again. Mr. H wrote an email detailing what Patient W told him:

> She then began to tell us about her negative interaction with the previous therapist [Grievant] concerning painful deep suctioning early in the shift where her trach airway almost came out of her stoma from some rough handling of her airway by the therapist (i.e. it was painful to her in the reinsertion of her trach tube back in her stoma). She said that she tried to convey to him that she was in some degree of pain at which time he started to verbally raise his voice in frustration directed at her saying words to the effect "That this is what you wanted" (i.e. that the patient requested to be suctioned). *** The patient opened up to [Dr. C] further and revealed that she was fearful of this therapist coming back into her room to suction her again the rest of his shift. *** I could see that replaying this ordeal of hers was making her not only fearful but also angry

by clenching her fists and kicking her left leg because of how helpless and vulnerable she must have felt at the hands of this health care professional.[2]

Mr. M spoke with Patient W. she told him, in part:

This is very difficult for me to talk about because it is very emotional for me. I didn't want to bring anything up because all of the care has normally been so good. Last night around 8 o'clock or so, I'm not great with time, [Grievant] came in to do his normal routine. I am not able to move much so when I hurt, I wiggle (kicking her left leg). This is all I can do and with my nerves slowly coming back, everything is very sensitive. He was tightening the trach ties tighter and tighter. I was kicking and wiggling because it hurt. He started yelling at me not to move and I was saying "ow, ow, ow". I kept saying there is something wrong. He was getting louder in the way he talked. The balloon felt like it came out and he pushed it back in. He said "I don't know what your problem is, you have to calm down." But it really hurt.

Then I asked to be suctioned, you know how you can feel and hear that you need suctioning, that is what was happening. He jammed the suction catheter down 3 times and it hurt. He then lectured me about my suction needs. He was belittling me in a way and his voice was getting louder and louder. I glared at him, then looked at the TV and closed my eyes, as that was all I could do.[3]

Grievant described his encounter with Patient W, in part:

The patient then indicated that she wanted suctioning. When I went to suction the patient, I flipped the cap up of the extension to so I didn't break the circuit. As soon as I flipped the cap up the patient began thrashing her head from side to side violently. I was shocked; I had never seen this type of aggressive behavior from her before. I asked her what was wrong and she indicated that she wanted to be disconnected from the ventilator when suctioned. I obliged the patient and disconnected her from the ventilator for suctioning. The patient then showed displeasure with facial expressions. I asked her what the problem was and she tried to tell me but I was unable to read her lips. Her husband came to the bedside and said "too tight". After asking several questions I determined the patient was indicating that the blue retaining strap was too tight so I loosened the strap.

[2] Agency Exhibit 1.

[3] Agency Exhibit 1.

> Before I attached the vent circuit to the patient, I place the circuit in the ventilator support arm to alleviate the weight of the circuit and thereby reducing the pressure of the trach flange on the skin to prevent a pressure ulcer from developing. Again, the patient began telling me something was bothering her. She wanted the vent circuit laying on her chest so I lowered the circuit arm until the vent circuit rested on her chest. I then proceeded to perform trach care with the patient using the prescribedsuction. I let the patient know when I was finished and asked her if I could do anything else for her. She said no and thank you. She had a smile on her face. Upon exiting the room, her husband told me thank you and I said you're welcome.[4]

On April 13, 2018, Grievant provided services to Patient J. Grievant directed the catheter into Patient's J's right lung. He was trying to "get that deep into the right lung." Grievant testified that he did not deep suction Patient J.

Mr. M spoke with Patient J about Grievant. Mr. M asked "Did you grab at his hand and try to pull them away when you were suctioned?" Patient J responded, "I did and he continued to suction me and wouldn't stop." Mr. M asked, "Did he ask if he could suction a second time?" Patient J responded, "Yes he did, and I said no, and he didn't suction again." Mr. M asked, "Does he suction differently than others?" Patient J answered, "Yes. He sections deep and just keeps going. It hurt and scared me."[5]

Grievant described his encounter with Patient J as follows:

> I auscultated patient for rhonchi bilaterally. I then asked patient if it was OK to suction and she communicated yes. I would like you to ask her and her mother if she asked this to confirm. Then I began suctioning patient with intent of suctioning her right lung. I suctioned 3 - 4 seconds while advancing the red rubber suction catheter approximately 12 cm. at which point the patient grabbed my hand and pushed it away. I was sympathetic to patient and apologized for any discomfort. I then asked patient if she would allow me to suction her left lung and she shook her head no so I didn't suction anymore. The patient's mother commented that that was the first time she saw her react like that. I then said I suctioned her as gently as possible and hyper oxygenated prior to suctioning. I then asked the mother if I did anything differently [than] anyone else who suctioned her and she said no, but that she reacted differently. I then told them that I would be back later to give a breathing treatment and left the room.

CONCLUSIONS OF POLICY

[4] Agency Exhibit 1.

[5] Agency Exhibit 2.

Policy 701 sets forth the Agency's Standards of Performance for its employees. Progressive performance improvement counseling steps include an information counseling (Step One), formal written performance improvement counseling (Step Two), suspension and/or performance warning (Step Three) and ultimately termination (Step Four). Depending upon the employee's overall work record, serious misconduct issues that may result in termination without prior progressive performance improvement counseling.

Serious Misconduct refers to acts or omissions having a significant impact on patient care or business operations. Examples include "mistreatment of a patient".

Gross Misconduct refers to acts or omissions having a severe or profound impact on patient care or business operations. Examples of gross misconduct include, "verbal harassment and/or physical abuse, of a patient" and "causing physical harm to a patient".

On March 1, 2018, Grievant mistreated Patient W because he treated her with deep suctioning. Deep suctioning was rarely to be used in the respiratory therapy profession and especially at the Unit. There is no reason to believe deep suctioning was the only way to treat Patient W. Patient W reacted to Grievant's deep suctioning by feeling intense pain and becoming afraid to ask for respiratory care for the remainder of Grievant's shift. The Agency has presented sufficient evidence to support the issuance of a Step 3 Formal Performance Improvement Counseling Form.

Grievant argued that deep suctioning was not prohibited. The evidence showed that deep suctioning was discouraged or frowned upon in Grievant's profession for patients like those in the Unit.

Upon the issuance of a Step 3 Formal Performance Improvement Counseling Form, a 90 day Performance Warning is appropriate. Policy 701 provides:

> The Performance Warning shall document that unsatisfactory progress, or failure to meet all performance and conduct expectations, at any time during the Performance Warning period shall normally result in termination.

On April 13, 2018, Grievant provided respiratory therapy to Patient J. Grievant's treatment was more aggressive than necessary. He was trying to get the catheter deep into Patient J's right lung. This caused Patient J to experience pain and made her cry. Patient J's mother requested that Grievant not be assigned to Patient J's care for the remainder of her stay at the Unit. Grievant did not meet all of the performance expectations of his position. The Agency has presented sufficient evidence to support the issuance of a Step 4, Formal Performance Improvement Counseling Form with removal.

Grievant argued that simply because a patient experienced pain, it did not mean that Grievant engaged in misconduct. For these two patients, however, Grievant used techniques that resulted in more pain than necessary. The pain was sufficient for neither patient to want to work again with Grievant.

There is little doubt that Grievant was passionate about helping patients. He did not intend to harm or mistreat his patients. The two patients in the Unit, however, were not appropriate for Grievant's style of providing respiratory therapy. The Agency presented sufficient evidence to supports its disciplinary actions.

Va. Code § 2.2-3005.1 authorizes Hearing Officers to order appropriate remedies including "mitigation or reduction of the agency disciplinary action." Mitigation must be "in accordance with rules established by the Department of Human Resource Management …."[6] Under 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. Thus, a hearing officer may mitigate the agency's discipline only if, under the record evidence, the agency's discipline exceeds the limits of reasonableness. If the hearing officer mitigates the agency's discipline, the hearing officer shall state in the hearing decision the basis for mitigation." A non-exclusive list of examples includes whether (1) the employee received adequate notice of the existence of the rule that the employee is accused of violating, (2) the agency has consistently applied disciplinary action among similarly situated employees, and (3) the disciplinary action was free of improper motive. In light of this standard, the Hearing Officer finds no mitigating circumstances exist to reduce the disciplinary action.

DECISION

For the reasons stated herein, the Agency's issuance to the Grievant of a Step 3 Formal Performance Improvement Counseling Form with a 12 hour suspension and performance warning is **upheld**. The Agency's issuance to the Grievant of a Step 4 Formal Performance Improvement Counseling Form with removal is **upheld**.

APPEAL RIGHTS

You may request an administrative review by EEDR within **15 calendar** days from the date the decision was issued. Your request must be in writing and must be **received** by EEDR within 15 calendar days of the date the decision was issued.

Please address your request to:

Office of Equal Employment and Dispute Resolution
Department of Human Resource Management

[6] Va. Code § 2.2-3005.

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 must also provide a copy of your appeal to the other party 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.

A challenge that the hearing decision is inconsistent with state or agency policy must refer to a particular mandate in state or agency policy with which the hearing decision is not in compliance. A challenge that the hearing decision is not in compliance with the grievance procedure, or a request to present newly discovered evidence, must refer to a specific requirement of the grievance procedure with which the hearing decision is not in compliance.

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.[1]

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

/s/ Carl Wilson Schmidt

Carl Wilson Schmidt, Esq.
Hearing Officer

[1] Agencies must request and receive prior approval from EEDR before filing a notice of appeal.