Issue: Group III Written Notice with termination (patient neglect); Hearing Date: October 2, 2001; Decision Date: October 4, 2001; Agency: Department of Mental Health, Mental Retardation and Substance Abuse Services; AHO: David J. Latham, Esquire; Case Number: 5291



# **COMMONWEALTH of VIRGINIA Department of Employment Dispute Resolution**

# **DIVISION OF HEARINGS**

# DECISION OF HEARING OFFICER

In re:

Case No: 5291

Hearing Date: Decision Issued: October 2, 2001 October 4, 2001

# APPEARANCES

Grievant Attorney for Grievant One witness for Grievant Representative for Agency Six witnesses for Agency

## **ISSUES**

Did the grievant's actions on May 24, 2001 warrant disciplinary action under the Commonwealth of Virginia Standards of Conduct? If so, what was the appropriate level of disciplinary action for the conduct at issue?

#### FINDINGS OF FACT

The grievant filed a timely appeal from a Group III Written Notice issued on August 3, 2001 because she had neglected a client. The grievant was discharged from employment as part of the disciplinary action. Following failure to resolve the grievance at the third resolution step, the agency head qualified the grievance for a hearing.

The Department of Mental Health, Mental Retardation and Substance Abuse Services (MHMRSAS) (Hereinafter referred to as "agency") has employed the grievant for 23 years. She is a Direct Service Associate II (charge aide). The patients at this facility are mentally retarded, physically handicapped, mentally ill or some combination of these conditions.

Section 201-1 of MHMRSAS Departmental Instruction 201 on Reporting and Investigation Abuse and Neglect of Clients states, in pertinent part: "The Department has zero tolerance for acts of abuse or neglect." Section 201-3 defines client neglect:

Neglect means failure by an individual, program or facility responsible for providing services to provide nourishment, treatment, care, goods or services necessary to the health, safety or welfare of a person receiving care or treatment for mental illness, mental retardation or substance abuse.<sup>1</sup>

The facility at which grievant was employed has promulgated its own policy statement on Abuse of Patients; the definition of neglect contained therein is identical to the above definition.<sup>2</sup>

Facility policy, on which repeated training has been conducted, requires that certain clients be under constant observation. Several patients have a propensity for putting foreign objects in their mouth and could injure themselves or accidentally ingest inappropriate items (these patients are designated "pica"). When a floor has five or more aides assigned, only two aides at a time may go on break or to lunch; if the floor has four or fewer aides, only one aide at a time may leave for break or lunch. This policy has been repeatedly stressed in numerous training sessions and the grievant was aware of this policy.

On May 24, 2001, grievant was the charge aide on one floor of a dormitory supervising three other direct service care workers (aides). Each aide supervises four or five clients. At about noon or shortly thereafter, two of the aides walked through the day hall (communal living room with chairs, couches, and television) and advised grievant that they were going on a smoke break just

<sup>&</sup>lt;sup>1</sup> Exhibit 8.

<sup>&</sup>lt;sup>2</sup> Exhibit 9.

outside the building. Neither aide signed out as required by policy.<sup>3</sup> Grievant was sitting in a chair in the day hall just outside the aides' office. The grievant may or may not have verbally responded but did acquiesce to their going on break. At about that time, a medication aide came into the day hall with a medication cart and began to administer prescribed medication to five clients scheduled for noontime administration. The third aide was in the dining room tending to the feeding of her four clients. She called to grievant for assistance with one client and the grievant went into the dining room (located off the corridor at the opposite end of the day room from where she had been sitting).<sup>4</sup>

One client had been sitting in a corner of the day hall when grievant left to go to the dining room. As soon as she left, the client quickly wheeled his wheelchair into the aides' office where he knocked a plate of food on the floor and emptied the contents of an aide's purse on the floor. The medication aide, who had been administering medicine to other clients, either heard the client or noticed him through the glass wall of the aides' office and called out to grievant for assistance. She then went into the aides' office and wheeled the client back into the day hall. Shortly thereafter, the other two aides returned to the day hall and grievant returned from the dining room. The client had a report card in his hand when taken from the aides' office but did not appear to have ingested either any food or foreign objects.<sup>5</sup> Grievant left the day hall unattended for between three and seven minutes.

The medication aide reported this incident to her supervisor (RN) at 1:00 p.m. on May 24, 2001; neither the aide nor the RN reported the incident to the facility director. On May 29, 2001, the RN went to the floor and found that the same two aides were on break together. However on this occasion, a different charge aide (grievant was not working on this date) had permitted two aides to take a break even though only four staff were working. The RN then reported both incidents to her supervisor (RN Coordinator) on May 29, 2001. The RNC promptly reported the incident to the Facility Director, who immediately assigned an investigator to the matter. The investigator completed his report on June 15, 2001 but was requested to conduct additional interviews and submitted his revised report on July 10, 2001. Following central office review, the disciplinary action at issue herein was issued on August 3, 2001. No one else was disciplined either for the May 24<sup>th</sup> or May 29<sup>th</sup> incidents.

The medication aide is not under the supervision of grievant. Her sole responsibility is to administer medication to clients and maintain constant control over the medication cart. She is not responsible for client control and care while administering medication. All employees, including grievant, have been repeatedly advised of the medication aide's limited responsibility and know that

<sup>&</sup>lt;sup>3</sup> Exhibit 5. Office Memorandum: *Breaks during Basement Program Time and Sign Out Sheets*, January 9, 2001.

<sup>&</sup>lt;sup>4</sup> See floor diagram – Exhibit 2.

<sup>&</sup>lt;sup>5</sup> See Exhibits 6 & 7 for background information on this client's condition and how he manifests pica.

they are not to consider her as aide for the purpose of observing pica patients. The medication aide is required to maintain constant control of her medication cart in order to avoid having other pica patients grab and ingest medication. A medication aide can leave her cart only if she sees a client in imminent danger.

One of the two aides who went for a smoke had been taking breaks with the second aide for some time prior to this incident notwithstanding the prohibition against two aides on break when only four were on duty. When the grievant would remind her of the prohibition, the aide would talk back to grievant and "give her a hard time." Over time, to avoid verbal conflict, the grievant simply acquiesced to this aide and did not voice objections when the two aides went on break together. The registered nurse coordinator has concluded that grievant is easily intimidated by difficult subordinates.

Grievant and the medication aide had worked together for about 20 years. Although they had been friendly in years past, they have "grown apart" in the last two years. Both maintain they are still able to work together but they no longer socialize as they had in the past.

All witnesses agree that, even though the client is 80 years old, he is extremely agile and quick. When left unattended, he is prone to grab almost any loose object in sight and often will put papers or clothes in his mouth.

## APPLICABLE LAW AND OPINION

The General Assembly enacted the <u>Virginia Personnel Act</u>, Va. Code § 2.1-110 et seq., establishing the procedures and policies applicable to employment within the Commonwealth. This comprehensive legislation includes procedures for hiring, promoting, compensating, discharging and training state employees. It also provides for a grievance 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 governmental interest in and responsibility to its employees and workplace. <u>Murray v. Stokes</u>, 237 Va. 653, 656 (1989).

Code § 2.1-116.05(A) sets forth the Commonwealth's grievance procedure and provides, in pertinent part:

It shall be the policy of the Commonwealth, as an employer, to encourage the resolution of employee problems and complaints . . . To the extent that such concerns cannot be resolved informally, the grievance procedure shall afford an immediate and fair method for the resolution of employment disputes which may arise between state agencies and those employees who have access to the procedure under § 2.1-116.09.

In disciplinary actions, the agency must show by a preponderance of evidence that the disciplinary action was warranted and appropriate under the circumstances.<sup>6</sup>

To establish procedures on Standards of Conduct and Performance for employees of the Commonwealth of Virginia and pursuant to §§ 2.1-114.5 of the <u>Code of Virginia</u>, the Department of Personnel and Training<sup>7</sup> promulgated Standards of Conduct Policy No. 1.60 effective September 16, 1993. The Standards of Conduct provide a set of rules governing the professional and personal 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. Section V.B.3 of the Commonwealth of Virginia's *Department of Personnel and Training Manual* Standards of Conduct Policy No. 1.60 provides that Group III offenses include acts and behavior of such a serious nature that a first occurrence normally should warrant removal [from employment].<sup>8</sup> The agency's policy on patient neglect provides that employees are subject to the full range of disciplinary action, up to and including termination of employment.<sup>9</sup>

The agency has demonstrated, by a preponderance of the evidence, and the grievant has acknowledged, that grievant did leave clients unattended for a period of at least three or more minutes. Grievant knew that pica clients must be observed at all times and that leaving them unattended violates a rule established by agency management. Moreover, failing to provide this required observation clearly fits within the definition of neglect as promulgated in the written agency policy. Further, grievant has admitted allowing two aides to take a break at the same time. This also violates written policy and contributed to not having enough staff available to provide constant observation. Thus, the agency has shown that disciplinary action was required in this case.

The standard disciplinary action in a case of abuse or neglect is termination of employment. However, both agency policy<sup>10</sup> and the Standards of Conduct provide for the consideration of mitigating circumstances in the implementation of disciplinary actions. Department Instruction 201 provides that disciplinary action is based on criteria including but not limited to: a) seriousness

<sup>&</sup>lt;sup>6</sup> § 5.8 Department of Employment Dispute Resolution *Grievance Procedure Manual* 

<sup>&</sup>lt;sup>7</sup> Now known as the Department of Human Resource Management (DHRM).

<sup>&</sup>lt;sup>8</sup> DHRM Policy No. 1.60, Standards of Conduct, September 16, 1993.

<sup>&</sup>lt;sup>9</sup> Exhibit 8. *Ibid.* 

<sup>&</sup>lt;sup>10</sup> Exhibit 8. *Ibid.* 

of the neglect, b) circumstances surrounding the incident and/or, c) the employee's work record. The Standards of Conduct states, in pertinent part:

While the disciplinary actions imposed shall not exceed those set forth in this policy for specific offenses, agencies may reduce the disciplinary action if there are mitigating circumstances, such as:

- a. conditions that would compel a reduction in the disciplinary action to promote the interests of fairness and objectivity; or
- b. an employee's long service or otherwise satisfactory work performance.<sup>11</sup>

After careful consideration of the evidence in this case, it is apparent that the above circumstances are present. First, the neglect in this case was less serious than other cases. Certainly, the potential for more serious consequences existed in this case and discipline was necessary to emphasize that potential. However, the grievant was distracted by the need to attend to another client. While she knew that the medication aide was not responsible for observing the other clients, it is understandable (although not excusable) that grievant might assume she would keep an eye on the clients in the same room.

Second, with regard to fairness and objectivity, the record reflects that grievant was the only person disciplined for the May 24th incident. The uncontroverted testimony established that the medication aide violated Departmental Instruction 201 when she failed to report the incident to the facility director. Further, the medication aide's supervisor, a registered nurse, also failed to report the incident to the facility director. Neither person was disciplined notwithstanding these clear policy violations.

On May 29, 2001, a virtually identical incident occurred in which the same two aides were allowed to go on break together and pica patients were left unattended for a period of time. Although no patients entered the aides' office on this occasion, the potential for a serious incident was precisely the same as the May 24<sup>th</sup> incident. The charge aide involved in the May 29<sup>th</sup> incident was not disciplined. The agency has offered no rationale for why grievant was disciplined but three other equally culpable employees were not disciplined. Thus the actions taken with regard to these four employees (including grievant) was disparate. This situation plainly compels a reduction in the discipline in order to demonstrate some modicum of fairness and objectivity.

The record in this case also establishes a third mitigating circumstance. The grievant has been employed for 23 years – a very long record of service to the Commonwealth. Moreover, all testimony indicates that grievant's performance during that time has been not only satisfactory but has exceeded expectations. She has never previously been disciplined. Grievant's supervisor

<sup>&</sup>lt;sup>11</sup> Section VII.C.1, DHRM *Standards of Conduct Policy No: 1.60*, effective September 16, 1993.

characterized grievant as conscientious and felt this incident was essentially an aberration. The RNC had worked with grievant for several years and has confidence in her.

Given the relatively less serious nature of this incident, the grievant's superior record throughout more than two decades of service, and the obviously disparate treatment, this case demands a reduction in discipline.

The evidence reflects that grievant has experienced difficulty controlling the actions of her subordinates. Therefore, the agency may wish to consider various options to address this issue (such as discipline of subordinates or demotion of grievant) in order to assure that policies are followed in the future.

## **DECISION**

The disciplinary action of the agency is modified.

The Group III Written Notice issued to the grievant on August 3, 2001 is AFFIRMED. However, the removal from employment is REVERSED and grievant is reinstated to her position with full back pay. The Written Notice shall remain in the grievant's personnel file for the length of time specified in Section VII.B.2.c of the Standards of Conduct.

# APPEAL RIGHTS

As Sections 7.1 through 7.3 of the Grievance Procedure Manual set forth in more detail, this hearing decision is subject to administrative and judicial review. Once the administrative review phase has concluded, the hearing decision becomes final and is subject to judicial review.

<u>Administrative Review</u> – This decision is subject to three types of administrative review, depending upon the nature of the alleged defect of the decision:

- 1. A request to reconsider a decision or reopen a hearing is made to the hearing officer. This request must state the basis for such request; generally, newly discovered evidence or evidence of incorrect legal conclusions is the basis for such a request.
- 2. A challenge that the hearing decision is inconsistent with state or agency policy is made to the Director of the Department of Human Resources Management. This request must cite to a particular mandate in state or agency policy. The Director's authority is limited to ordering the hearing officer to revise the decision to conform it to written policy.
- 3. A challenge that the hearing decision does not comply with grievance procedure is made to the Director of EDR. This request must state the

specific requirement of the grievance procedure with which the decision is not in compliance. The Director's authority is limited to ordering the hearing officer to revise the decision so that it complies with the grievance procedure.

A party may make more than one type of request for review. All requests for review must be made in writing, and received by the administrative reviewer, within **10 calendar** days of the **date of the original hearing decision.** (Note: the 10-day period, in which the appeal must occur, begins with the date of **issuance** of the decision, **not receipt** of the decision. However, the date the decision is rendered does not count as one of the 10 days; the day following the issuance of the decision is the first of the 10 days). A copy of each appeal must be provided to the other party.

A hearing officer's original decision becomes a **final hearing decision**, with no further possibility of an administrative review, when:

- 1. The 10 calendar day period for filing requests for administrative review has expired and neither party has filed such a request; or,
- 2. All timely requests for administrative review have been decided and, if ordered by EDR or HRM, the hearing officer has issued a revised decision.

## Judicial Review of Final Hearing Decision

Within thirty days of a final decision, a party may appeal on the grounds that the determination is contradictory to law by filing a notice of appeal with the clerk of the circuit court in the jurisdiction in which the grievance arose. The agency shall request and receive prior approval of the Director before filing a notice of appeal.

> David J. Latham, Esq. Hearing Officer