Issue: Group I Written Notice (failure to follow established written policy); Hearing Date: May 9, 2002; Decision Date: May 14, 2002; Agency: Department of Mental Health, Mental Retardation and Substance Abuse Services; AHO: David J. Latham, Esquire; Case Number: 5430

COMMONWEALTH of VIRGINIA

Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case No: 5430

Hearing Date: May 9, 2002
Decision Issued: May 14, 2002

APPEARANCES

Grievant
Representative for Grievant
Two witnesses for Grievant
Facility Director
Legal Assistant Advocate for Agency
Three witnesses for Agency

ISSUES

Did the grievant's actions on December 30, 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 I Written Notice issued on February 12, 2002 because she failed to respond to a call to attend to a resident within one hour.[1] Following failure to resolve the grievance at the third resolution step, the agency head qualified the grievance for a hearing.[2]

The Department of Mental Health, Mental Retardation and Substance Abuse Services (MHMRSAS) (Hereinafter referred to as "agency") has employed the grievant as a licensed practical nurse for five years. She has previously been counseled about taking too long to complete assigned tasks.[3] On multiple occasions grievant had called to say she was on her way but then did not show up.

The grievant's primary core responsibility is nursing care. The single most important measure of this core responsibility is "Responds to reports of illnesses and injuries of residents to the cottage within one hour for non-emergencies and within 10 minutes for emergencies."[4] Grievant's supervisor had been stressing the need to respond promptly to reports of resident illness for several months prior to this incident. In November 2001, she added this specific requirement to each employee's Employee Work Profile in order to emphasize the importance of responding promptly to illness or injury reports.

On December 30, 2001, cottage staff had become concerned about the condition of resident H. He had a terrible cold, lots of congestion, difficulty breathing, diarrhea and was very weak. At 8:20 a.m., one of the staff called the infirmary and spoke with the night shift charge nurse (a registered nurse RN). The RN said she would advise the day shift nurse who was assigned to cover the cottage (grievant). By 9:05 a.m., grievant had not yet come to the cottage. Cottage staff called the infirmary again and spoke directly with grievant.[5] Grievant said that she would come to the cottage soon because she had to bring medicine to another resident. Grievant instructed staff to place resident H in the smallest bathroom, turn on the hot water and let it steam up the room to facilitate the resident's breathing until she could get to the cottage. Staff followed her instructions.[6]

At 9:25 a.m., a team leader from an adjoining cottage called the Assistant Program Manager (APM) at her home.[7] She reported that the staff in the

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[1] Exhibit 10. Written Notice, issued February 12, 2002.
[2] Exhibit 11. Grievance Form A, filed March 7, 2002.
[3] Exhibit 15. Memorandum to grievant from her supervisor, February 9, 2001.
[4] Exhibit 1. Grievant's *Employee Work Profile*, signed November 27, 2001.
[5] Exhibit 3. Memorandum prepared by cottage staff member, January 9, 2002.
[6] The hot water in cottages is temperature limited to prevent inadvertent injury to the residents with mental retardation. Therefore, the cottage staff decided on their own to boil pans of water on the stove and take them into the bathroom to create steam.
[7] The Assistant Program Manager supervises four cottages, each of which house nine residents.

adjoining cottage had called her because they were becoming more concerned about the resident's deteriorating condition. At 9:30 a.m., the APM called the staff in the resident's cottage to obtain detailed information. After this discussion, the APM called the infirmary at about 9:45 a.m. and spoke with a day shift nurse. The nurse said that grievant was not in the infirmary at that time. The APM requested that the nurse page grievant and have her go promptly to the resident's cottage. The cottage is about a three-minute walk from the infirmary.[8]

Grievant arrived at the resident's cottage at 10:20 a.m.[9] She concluded that the resident had a head cold but that his lungs were clear. She left about one hour later. By noon, the resident's condition had continued to deteriorate and staff again called the APM. The APM called the day shift charge nurse at the infirmary who personally went to the cottage to examine the resident. After the RN examined the resident, she made arrangements to have the resident taken to the emergency room of a local hospital. At the hospital, the resident was diagnosed with pneumonia and admitted that same afternoon; he died nine days later on January 8, 2002 due to multiple problems.

Other nurses who failed to respond within the one-hour time limit have been disciplined with written notices.

APPLICABLE LAW AND OPINION

The General Assembly enacted the Virginia Personnel Act, Va. Code § 2.2-2900 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. Murray v. Stokes, 237 Va. 653, 656 (1989).

Code § 2.2-3000 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

[8] Grievant contended the distance between this cottage and the infirmary is 10 minutes. However, an aerial photograph (which is on the wall of the hearing room) of the facility campus reveals that, at most, the distance is about a three-minute walk.

[9] Exhibit 2. Memorandum to Facility Director from Assistant Program Manager, January 8, 2002.

> the resolution of employment disputes which may arise between state agencies and those employees who have access to the procedure under § 2.2-3001.

In disciplinary actions, the agency must show by a preponderance of evidence that the disciplinary action was warranted and appropriate under the circumstances.[10]

To establish procedures on Standards of Conduct and Performance for employees of the Commonwealth of Virginia and pursuant to § 2.2-1201 of the Code of Virginia, the Department of Personnel and Training[11] 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 I offenses include types of behavior least severe in nature but which require correction in the interest of maintaining a productive and well-managed work force. One example of a Group I offense is inadequate or unsatisfactory work performance.[12]

The issue in this case is whether grievant complied with the requirement in her work profile to respond to a report of illness in a cottage within one hour of notification. The undisputed evidence establishes that cottage staff notified a nurse in the infirmary at 8:20 a.m. about the resident's condition. However, grievant denies that the nurse told her about the phone call from the cottage. That nurse did not testify and the agency presented no other evidence to show that the nurse relayed the message to grievant. Therefore, the agency has not shown that grievant knew about the resident's condition prior to 9:05 a.m.

Grievant also denies receiving the call at 9:05 a.m. from cottage staff. However, a preponderance of evidence establishes that she did receive that call at 9:05 a.m. First, memoranda prepared by two different people within ten days of the event establish the time of the second call as 9:05 a.m. By contrast, grievant's witness statement prepared at about the same time does not mention times for any of the events of December 30, 2001.[13] Second, and even more persuasively, grievant contends she first learned about the problem at about 9:30 a.m. However, by that time, cottage staff had already been following grievant's

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[10] § 5.8 Department of Employment Dispute Resolution *Grievance Procedure Manual*

[11] Now known as the Department of Human Resource Management (DHRM).

[12] Exhibit 13. Chapter 14: *Standards of Conduct and Client Abuse*, DMHMRSAS Employee Handbook.

[13] Exhibit 4. Grievant's witness statement, January 11, 2002.

instructions to treat the resident with steam in the bathroom. The staff could only have been conducting this treatment if grievant had spoken with them earlier. Therefore, it is concluded that grievant knew about the resident's illness not later than 9:05 a.m.

Grievant arrived at the resident's cottage at 10:20 a.m. Although grievant now contends that she arrived about 10:00 a.m., this is not supported by the evidence for two reasons. First, the two detailed memoranda about the events written by the APM and by cottage staff agree that grievant arrived at 10:20 a.m. Second, in her own statement, written only 12 days after the event, grievant states, "I don't recall the time" that she arrived at the cottage.[14] If she didn't recall the time then, it is not credible that she now remembers the time more than four months after the event. Accordingly, it is concluded that grievant arrived at the cottage at least one hour and 15 minutes after being notified of the resident's illness. This constitutes inadequate or unsatisfactory work performance.

Grievant contends that she was unaware of the one-hour response requirement; she believed that the policy was to respond "as soon as she could." Grievant's assertion is not credible for three reasons. First, grievant's supervisor had been emphasizing this requirement for several months during staff meetings. Second, grievant signed her Work Profile on November 27, 2001 acknowledging that her primary core responsibility was patient care and that she is obligated to respond to non-emergencies within one hour. Third, grievant was aware that two other nurses had been disciplined for failure to respond promptly to resident illnesses.

Grievant testified that she was delayed in getting to resident H's cottage because she had to restock her nurse's kit before she left. However, this assertion is contradicted by grievant's assertion that she always keeps her kit well-stocked and that she had been making rounds at another cottage cluster between 9:00 a.m. and 9:30 a.m. She did not have any emergencies during the rounds and administered no treatment requiring supplies. If she had been making rounds and always keeps her kit well stocked, it is not logical that she would have had to spend 30-35 minutes restocking her kit between 9:30 a.m. and 10:15 a.m.

Finally grievant argues, in effect, that a few minutes more than an hour shouldn't be considered so seriously. If there had been extenuating circumstances, this argument might have merit. However, grievant has produced no evidence that she was attending to any other emergency that prevented her from going to the cottage. Moreover, grievant knew, or reasonably should have known, that the resident's condition was potentially serious. She received a call from the staff at 9:05 a.m. Only 25 minutes later at 9:30 a.m., the charge nurse told her that the APM had just called about the same resident. The fact that two calls about the same resident came in within a half hour should have alerted her

[14] Exhibit 4. *Ibid*.

to the seriousness of the resident's illness. Notwithstanding this, the grievant did not go to the cottage for another 40 minutes after the second notification.

DECISION

The disciplinary action of the agency is affirmed.

The Group I Written Notice issued to the grievant on February 12, 2002 is AFFIRMED. The disciplinary action shall remain active pursuant to the guidelines in Section VII.B.2 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.

Administrative Review – 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.

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David J. Latham, Esq.
Hearing Officer