Issue: Group III Written Notice with termination (patient neglect); Hearing Date: 05/19/03; Decision Issued: 05/21/03; Agency: DMHMRSAS; AHO: David J. Latham, Esq.; Case No. 5716

COMMONWEALTH *of* VIRGINIA

Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case No: 5716

Hearing Date: May 19, 2003
Decision Issued: May 21, 2003

APPEARANCES

Grievant
Acting Facility Director
Advocate for Agency
One witness for Agency

ISSUES

Did the grievant's actions 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 for neglecting a patient on October 4, 2002.[1] As part of the disciplinary action, grievant was removed from state employment. 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 (hereinafter referred to as "agency") has employed the grievant as a psychiatric technician for less than three years.[3] Grievant has one other active prior disciplinary action for excessive absenteeism.[4] She had previously been counseled about patient neglect when she was found slumped in a chair and appeared to be sleeping.

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." Neglect is defined as:

> 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.[5]
>
> It is expected that a facility director will terminate [the employment of] an employee(s) found to have abused or neglected a client.[6]

The facility has a policy regarding "Unit Coverage." The unit charge nurse assigns staff at designated intervals throughout the shift to provide adequate coverage. Among the responsibilities of staff assigned to Unit Coverage are circulating and completing hall rounds every fifteen minutes, knocking on and opening closed doors, maintaining presence for the patients, assuring that patients do not enter the rooms of other patients, reporting unusual patient behavior to the charge nurse, and supporting patients to adhere to prescribed boundaries.[7] When first hired, grievant was trained on unit coverage

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[1] Exhibit 1. Written Notice, issued February 10, 2003. NOTE: The agency acknowledged that the description of the offense erroneously gives the date of offense as October 10, 2002. The correct date was October 4, 2002.
[2] Exhibit 1. Grievance Form A, filed March 10, 2003.
[3] Exhibit 5. Employee Work Profile, November 25, 2002.
[4] Exhibit 6. Group I Written Notice, issued December 4, 2002.
[5] Exhibit 8. Section 201-3, Departmental Instruction 201(RTS)00, *Reporting and Investigating Abuse and Neglect of Clients*, April 17, 2000.
[6] Exhibit 8. Section 201-8, *Ibid*.
[7] Exhibit 3. Facility Policy *Unit Coverage*, July 1998.

during orientation, observed others performing unit coverage, and was then observed by the trainer.[8]

Grievant worked the night shift (11:00 p.m. – 7:30 a.m.) on October 4, 2002. Grievant was assigned to a unit different from her regular unit that night to cover a staffing shortage. The unit to which she was assigned had 22 patients and was staffed that night by two nurses and three psychiatric technicians. This unit is the admissions unit and generally houses patients who have been in the facility for less than 30 days. The charge nurse assigned unit coverage to grievant from 2:00 a.m. to 3:00 a.m. Grievant and one of the other technicians made rounds from about 2:10 a.m. to about 2:20 a.m. One female patient was awake and sitting in the hall. She followed the two technicians as they made rounds and then again resumed sitting in the hall across from the room of a male patient. The patient had been admitted on October 3, 2002 for psychosis, was delusional, hallucinating, and conceptually disorganized. At the beginning of the shift, she was wandering the halls and had made several attempts to enter a male patient's room stating that she needed her husband.[9] Staff had to frequently redirect the patient to keep her from entering the male patient's room.

When not assisting patients, the psychiatric technicians sit at a table at the corner of an L-shaped hallway so that they can see down both corridors of the unit. The person assigned to Unit Coverage is expected to watch both corridors to monitor patient activity. Following rounds, the three technicians were sitting at the table doing paperwork.[10] Grievant was the only technician sitting facing the female patient who was sitting in the hall several feet in front of her. At about 2:40 a.m., the other female technician turned around to check on the female patient and noted that she was no longer in the hall. She quickly checked the patient's room, then checked a male patient's room and found the female patient in the male patient's bed having sex with him.

The agency considers sexual encounters between patients to be high-risk behavior because of the risk of pregnancy, sexually transmitted diseases (STD), and because of the unstable mental condition of the patients. When a sexual encounter occurs, the agency is obligated to report the incident to the families of both patients, the agency's central office, the Office of Inspector General, the Virginia Office of Protection Advocacy, and the Human Rights Commission. These steps were taken in the instant case.

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[8] Exhibit 4. Nursing Skill Development Competency Checklist, summer 2000.

[9] In fact, the female patient is separated from her husband and he was not a patient of the hospital.

[10] During this time, the two nurses were in the chart room working on patient charts and were not in a position to observe patient activity in the hall.

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 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.[11]

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 Human Resource Management 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].[12] An example of a Group III offense is violating safety rules where there is a threat of physical harm.

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[11] § 5.8, EDR *Grievance Procedure Manual,* effective July 1, 2001.
[12] Exhibit 7. DHRM Policy No. 1.60, *Standards of Conduct*, September 16, 1993.

The agency alleged that grievant would not help patients, that she would conceal her nametag, and that she was argumentative with patients. Grievant denied these allegations and the agency failed to produce any first-hand witnesses to substantiate the allegations. Therefore, the agency failed to shoulder the burden of proof with regard to these charges.

The agency has demonstrated, by a preponderance of evidence, that grievant was assigned to unit coverage between 2:00 a.m. and 3:00 a.m. on the night of October 4, 2002. Grievant had been trained in the responsibilities of unit coverage, had been assigned to unit coverage in the past, and knew that she was assigned to unit coverage when this incident occurred. Grievant's primary responsibility at this time included assuring that patients did not enter the rooms of other patients. Grievant knew since the beginning of the shift that the female patient had been repeatedly attempting to enter the male patient's room and that she required monitoring to prevent this from occurring.

Grievant has repeatedly stressed that she was not specifically assigned to watch the female patient, and that she was not assigned to constant observation. The agency acknowledges this to be true but counters that, pursuant to the unit coverage assignment, grievant was assigned to monitor the entire unit, including the female patient. At the time of the incident, most patients were asleep and two were watching television in the dayroom; the female patient was the only one in the hallway. Further, grievant knew that the female patient had made several attempts to enter the male patient's bedroom. Therefore, grievant should have been able to easily monitor the female patient's movements, especially since the patient was sitting just down the hall, in full view of grievant.

Grievant argues that one of the other technicians should not have been sitting with her back to the patient, thereby inferring that it was the other technician's responsibility to have been watching the patient. This argument is illogical because it suggests that the other technician was more responsible for the patient than the grievant, even though grievant was the person assigned to unit coverage.

Grievant also contends that she was doing paperwork associated with the completion of rounds when the female patient entered the male patient's room. While paperwork may be required, grievant's primary responsibility was to assure that the female patient did not enter the male patient's room. Therefore, even if grievant was doing paperwork, she was obligated to look up frequently in order to assure that the female patient was still sitting in the hallway.

Grievant asserted that she had not been assigned to unit coverage, however, the nursing assignment sheet and other testimony demonstrated that she had been assigned to unit coverage. Grievant had argued to the Facility Director that the unit to which she was regularly assigned did not have "Unit Coverage." However, a review of that unit's records revealed that unit coverage

assignments were regularly made and that grievant was familiar with the responsibilities. Finally, grievant maintained that she had not been trained on unit coverage procedures. However, the agency's documentation reveals that grievant was, in fact, trained on how to perform unit coverage.

The procedure for the person assigned to unit coverage requires her to make patient rounds every 15 minutes. Grievant had made rounds at 2:10 a.m. Accordingly she should have made rounds again at 2:25 a.m. and at 2:40 a.m. but failed to do so.

One of the basic tenets of the Standards of Conduct is the requirement to promptly issue disciplinary action when an offense is committed. As soon as a supervisor becomes aware of an employee's unsatisfactory behavior or performance, or commission of an offense, the supervisor and/or management should use corrective action to address such behavior.[13] Management should issue a written notice as soon as possible after an employee's commission of an offense.[14] One purpose in acting promptly is to bring the offense to the employee's attention while it is still fresh in memory. A second purpose in disciplining promptly is to prevent a recurrence of the offense. When, as in this case, a detailed investigation is required, it is not uncommon for the investigation and central office review to take up to four weeks.

In this case, the incident occurred on October 4, 2002. An investigator was assigned and she completed her investigation on October 16, 2002. The report was forwarded to the central office where it was reviewed and returned to the facility director on October 30, 2002. However, discipline was not issued until more than three months later - on February 10, 2003. The time taken to investigate and complete central office review was reasonable, but the delay of three months to issue discipline appears inordinate. The agency explained that the facility director who received the central office report left the agency in mid-November and that the matter then "fell between the cracks."[15] However, notwithstanding the delay in issuance of discipline, the offense constituted patient neglect and is therefore an offense that warrants removal from employment.

The agency considered both mitigating and supporting circumstances. Grievant has been employed for less than three years. She had received training on the responsibilities of unit coverage, and understood the written policy. She had performed unit coverage in the past and knew that she was the sole person

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[13] Exhibit 7. Section VI.A. *Ibid.*
[14] Exhibit 7. Section VII.B.1. *Ibid.*
[15] The hearing officer appreciates that a top management change can be disruptive and that the new acting facility director undoubtedly had a very full plate when she assumed her new position. However, when the offense is as serious as patient abuse or neglect, it is vital that discipline be administered swiftly to prevent a recurrence of the same behavior. Accordingly, it is suggested that the facility establish a tracking log to assure that cases involving abuse or neglect are monitored, kept on track, and brought to a prompt conclusion. Such a log could be maintained by a designated human resources employee to assure accountability.

assigned to unit coverage between 2:00 a.m. and 3:00 a.m. Her past behavior of sleeping during working hours was potentially neglectful of patients. Considering all these circumstances, there is insufficient basis to reduce the standard discipline for this offense.

DECISION

The disciplinary action of the agency is affirmed.

The Group III Written Notice issued to the grievant on February 10, 2003 and her removal from employment are hereby UPHELD.

APPEAL RIGHTS

You may file an administrative review request within **10 calendar** days from the date the decision was issued, if any of the following apply:

1. If you have new evidence that could not have been discovered before the hearing, or if you believe the decision contains an incorrect legal conclusion, you may request the hearing officer either to reopen the hearing or to reconsider the decision.

2. 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 decision. You must state the specific policy and explain why you believe the decision is inconsistent with that policy.

3. If you believe that the hearing decision does not comply with the grievance procedure, you may request the Director of EDR to review the decision. You must state the specific portion of the grievance procedure with which you believe the decision does not comply.

You may request more than one type of review. Your request must be in writing and must be **received** by the reviewer within 10 calendar days of the date the decision was issued. You must give a copy of your appeal to the other party. The hearing officer's **decision becomes final** when the 10-calendar day period has expired, or when administrative requests for review have been decided.

You may request a judicial review if you believe the decision is contradictory to law.[16] You must file a notice of appeal with the clerk of the circuit court in the

[16] An appeal to circuit court may be made only on the basis that the decision was *contradictory to law,* and must identify the specific constitutional provision, statute, regulation or judicial decision that the hearing decision purportedly contradicts. Virginia Department of State Police v. Barton, 39 Va. App. 439, 573 S.E.2d 319 (2002).

jurisdiction in which the grievance arose within **30 days** of the date when the decision becomes final.[17]

[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]

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David J. Latham, Esq.
Hearing Officer

[17] Agencies must request and receive prior approval from the Director of EDR before filing a notice of appeal.