Issue: Group III Written Notice with termination (patient neglect); Hearing Date: 06/04/03; Decision Issued: 06/10/03; Agency: DMHMRSAS; AHO: David J. Latham, Esq.; Case No. 5728

COMMONWEALTH of VIRGINIA

Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case No: 5728

Hearing Date: June 4, 2003
Decision Issued: June 10, 2003

APPEARANCES

Grievant
Representative for Grievant
Facility Director
Advocate for Agency
Four witnesses 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 March 15, 2003.[1] As part of the disciplinary action,

[1] Exhibit 1, p.1. Written Notice, issued April 7, 2003.

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 Development Disabilities Specialist II for three years.

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.[3]

The facility has promulgated Guidelines for General Cottage Policies that provide, in pertinent part:

> 5.A.1. The shift leader is responsible for leadership and direction on her shift. This includes ensuring ... that residents are properly supervised at all times, and that administrative duties are completed. Any problems concerning resident services, staff performance, or administrative duties must be reported to the team leader, APM, or shift supervisor.
>
> 5.A.6. The cottage shift leader will meet with on-coming shift leader ... All relevant information, especially unusual behaviors, events, or illness, must be discussed.
>
> 5.B.1. All significant resident events including ... medical events or problems, ... use of time-out room or restraint must be recorded in the ID Note section as they occur. Ensure that injuries ... are recorded. [4]

Grievant participated in and passed a two-day standard first aid training course on March 20-21, 2001.[5]

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[2] Exhibit 1, p.2. Grievance Form A, filed April 16, 2003.
[3] Exhibit 7. Section 201-3, Departmental Instruction 201(RTS)00, Reporting and Investigating Abuse and Neglect of Clients, April 17, 2000.
[4] Exhibit 6. Programming Guideline No. 49. December 2002.
[5] Exhibit 4. American Red Cross *Course Record Addendum*.

On March 15, 2003, grievant was the shift leader during the evening shift (1:45 p.m. to 10:15 p.m.) in a cottage housing 10 clients with mental retardation. Grievant supervised three other employees on that shift. The night shift consists of only two employees who work from 10:00 p.m. to 6:00 a.m.[6] During the fifteen-minute overlap from 10:00 p.m. to 10:15 p.m. both shifts are required to be in the cottage to exchange information about any changes in client behavior, noteworthy events, or anything else that would impact client care. At some time between 9:45 p.m. and 9:55 p.m., a male client with a history of aggressive and explosive behavior and self-infliction of injury, sustained a significant gash (1.5 inches in length requiring four staples to close) on the right, rear of his head near the crown. The testimony is conflicting as to how and where in the cottage this wound was sustained.[7] Undisputed medical testimony established that a head wound of that size would have bled profusely. Two of the evening shift staff then placed the client in the "time-out" room.[8] At 10:00 p.m. two of grievant's subordinates left the facility even though their shift didn't end until 10:15 p.m.

Sometime between 10:00 and 10:05 p.m., the night shift leader arrived at the cottage to begin his shift. Soon after entering the cottage, he noticed that the client was in the time-out room and that no staff person was holding the deadman switch. He entered the time-out room and found the client in a fetal position. He observed that the client had a gaping wound on his head that was still bleeding. He asked the evening shift staff what had happened and they denied knowledge of the injury. He then directed an evening shift employee to summon medical assistance from the infirmary. A call was made sometime between 10:15 p.m. and 10:30 p.m. to the Security/Reception unit. That unit called over the intercom to alert the nurse of the need for medical assistance at about 10:32 p.m. At about 10:35 p.m., a licensed practical nurse arrived from the infirmary and administered first aid. When she arrived, there was only a small trickle of blood coming from the wound. She summoned an ambulance, which arrived at 10:45 p.m. At 11:00 p.m., the ambulance transported the client to the hospital where his wound was treated.

An investigator was notified to come to the scene at 10:44 p.m. He searched the cottage but found no evidence of blood, bloodied clothes, or bloodied compresses, anywhere in the cottage.[9]

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[6] Exhibit 5. Programming Guideline No. 21, February 2000.

[7] Although the consensus version from the evening shift was that the client slipped and fell while running towards the television, at least one evening shift employee said the incident may have happened in the time-out room

[8] Each cottage has a small room into which clients who are acting aggressively are placed until their behavior is corrected. The room contains a television camera that is monitored by a staff member who sits outside the room to assure that the client does not inflict any harm on himself. The room is locked and the staff member holds a "deadman switch" that automatically unlocks the door if the staff person leaves.

[9] One of the evening shift employees had stated that he had observed blood in both areas. See Exhibit 2, p. 10. Assistant Program Manager's witness statement, March 21, 2003.

Grievant left the facility at 10:15 p.m. before medical assistance had arrived.[10] Before leaving, he also failed to write up the incident, as required, in the interdisciplinary notes or anywhere else.

All four evening shift employees, including grievant, were removed from state employment as a result of this incident.

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

[10] Exhibit 2, p. 7. Grievant's written statement, March 19, 2003.
[11] § 5.8, EDR Grievance Procedure Manual, effective July 1, 2001.

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.

Because the client's head wound was on the right back of his head and appears inconsistent with running and falling forward, a question remains as to how the wound was actually sustained. The lack of any evidence of blood where the client was purportedly injured, and the conflicting evidence about where in the cottage the injury occurred further strengthens the possibility that the wound was sustained in a manner different from the witnesses' testimony. However, that issue is not before the hearing officer. Therefore, this decision addresses only the issue of the grievant's actions subsequent to the injury being incurred.

The agency has demonstrated, by a preponderance of evidence, that patient neglect occurred subsequent to the injury and that grievant was, in large measure, responsible for that neglect. As a caretaker of clients with mental retardation, grievant's primary obligation was to assure the health and safety of the clients. Moreover, as the shift leader of three other employees, grievant had an even higher duty and obligation to assure that both he and his subordinates took appropriate steps to address the client's injury when it occurred.

Here, a client sustained a serious injury that required immediate medical attention and the care of a physician to suture the wound. This should have been immediately obvious even to an untrained person. However, grievant was not untrained; he had received extensive Red Cross first aid training. Grievant now avers that he had cleaned up some of the client's blood. The evidence does suggest that efforts had been made to clean up not only blood on the client but from anywhere else in the cottage where it may have spilled. Grievant also contends that he directed another employee to call for medical assistance and to write up the incident in the ID Note records. However, this contention is not corroborated by either testimony or written statements. Moreover, even if grievant had directed someone else to take these steps, the fact is that a call for assistance was not made until the on-coming night shift leader directed someone to do it. As team leader, grievant cannot just tell others to perform actions and then absolve himself of responsibility. As the leader, he is responsible to follow up and assure that his instructions are actually complied with. He failed to do this and just left the facility without even waiting for medical assistance to arrive.

[12] Exhibit 8. DHRM Policy No. 1.60, Standards of Conduct, September 16, 1993.

Grievant testified that he deescalated the client, administered first aid to the wound, and gave the client a complete head-to-toe shower before the night shift supervisor arrived in the cottage. Between April 3 and April 7, 2003, grievant gave a written response containing his version of events to the facility director.[13] Grievant lists in detail the actions he took at the time of the incident. However, his memorandum fails to state what type of first aid he administered to the patient, and fails to state that he gave the client a shower. His failure to mention these crucial details in his written statement, which he wrote less than three weeks after the incident, raises a question as to whether the client was really given a shower. Whether grievant was actually given a shower is, by itself, of relatively little consequence. However, the inconsistency in grievant's versions of the event taints his credibility.

Grievant's credibility is further tainted by another inconsistency in his testimony. He repeatedly testified during the hearing that the client was not placed in the time-out room. However, his own written statement, as well as the written statements of all three subordinates confirms that the client was placed in the time-out room.[14] This was further corroborated by the testimony of both the Assistant Program Manager and the night shift team leader. The consistent testimony of agency witnesses established that a client who has been injured should not be locked in a time-out room. Rather, medical assistance should be immediately summoned to address the injury. It appears that grievant now contends the client was not placed in the time-out room because he recognizes that was the wrong action to have taken, and he is attempting to retroactively rehabilitate his behavior. It is also worth noting that none of grievant's three subordinates made any mention in their written statements that grievant gave the client either first aid or a shower.

Although it cannot be conclusively demonstrated, it appears that after being injured, the client was cursorily cleaned up and placed in the time-out room at the end of the shift in the hope that his injury would not be noticed until after the evening shift employees had all left. Most estimates place the time of injury at 9:45 or 9:48 p.m. It is undisputed that the call for medical assistance occurred only after the night shift leader arrived. It is also undisputed that neither grievant nor his subordinates documented the event prior to the end of the shift. The fact that these two critical actions were not taken is consistent with the apparent attempt to delay discovery of the injury until after the evening shift employees had left the facility.

Grievant contends that blood did not get on the patient's clothes. While there is no direct evidence to dispute his contention, it is difficult to imagine a

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[13] Exhibit 1, pp. 4 & 5. Memorandum from grievant to facility director, undated.

[14] Exhibit 2, pp. 6, 7, 14 & 15. Written statements of three subordinates and grievant, March 19 & 21, 2003.

large, profusely bleeding head wound that would not have resulted in at least some blood falling on the client's clothes.

DECISION

The disciplinary action of the agency is affirmed.

The Group III Written Notice and the removal of grievant from state employment on April 7, 2003 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.
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> 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.
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> 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.[15] You must file a notice of appeal with the clerk of the circuit court in the

[15] 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.[16]

[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

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