Issue: Group III Written Notice with termination (gross negligence); Hearing Date: 07/09/04; Decision Issued: 07/16/04; Agency: DOC; AHO: David J. Latham, Esq.; Case No.: 754

COMMONWEALTH of VIRGINIA

Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case No: 754

Hearing Date: July 9, 2004
Decision Issued: July 16, 2004

PROCEDURAL ISSUE

Grievant contends that she did not receive procedural due process in connection with the issuance of discipline. All claims of noncompliance should be raised immediately. By proceeding with the grievance after becoming aware of a procedural violation, one may forfeit the right to challenge the noncompliance at a later time. The procedure to remedy noncompliance is detailed in the grievance procedure.[1] In this case, grievant did not request a ruling from the Department of Employment Dispute Resolution regarding the alleged noncompliance. Therefore, grievant has forfeited her right to challenge the noncompliance. In any case, this hearing has provided grievant with full procedural due process regarding the disciplinary action.

APPEARANCES

Grievant
Attorney for Grievant

[1] §6.3, Department of Employment Dispute Resolution (EDR) *Grievance Procedure Manual*, effective July 1, 2001.

One witness for Grievant
Warden
Head Nurse

ISSUES

Did grievant's conduct warrant disciplinary action under the Standards of Conduct? If so, what was the appropriate level of disciplinary action for the conduct at issue? Did the agency misapply any regulations, policies, procedures or rules?

FINDINGS OF FACT

The grievant filed a timely grievance from a Group III Written Notice issued for gross negligence of medication errors on three separate occasions with three different inmates.[2] As part of the disciplinary action, grievant was removed from employment. Following failure of the parties to resolve the grievance at the third resolution step, the agency head qualified the grievance for a hearing.[3]

The Department of Corrections (DOC) (Hereinafter referred to as "agency") has employed grievant for six years. She is a Licensed Practical Nurse (LPN). Grievant has accumulated three active prior disciplinary actions – a Group II Written Notice for failure follow a supervisor's instructions and perform assigned work,[4] a Group I Written Notice for use of obscene language[5] and, a Group I Written Notice for failure to report to work as scheduled without proper notice to supervision.[6] All three disciplinary actions remain active. Grievant received a notice of substandard performance in January 2004 which put her on notice that she needed to improve, *inter alia*, her documentation.[7]

The facility's institutional operating procedure provides that all medications are to be recorded on the Medication Administration Record (MAR) to include start date, stop date, drug name, drug strength, directions, and time they are to be administered.[8] For new admissions, the policy provides that the inmate's medical record will be reviewed by health care staff upon admission to ensure that treatment is not interrupted.[9] The Department of Corrections has

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[2] Agency Exhibit 1. Group III Written Notice, issued March 5, 2004.
[3] Agency Exhibit 3. Grievance Form A, filed April 1, 2004.
[4] Agency Exhibit 8. Group II Written Notice, issued September 17, 2001.
[5] Agency Exhibit 8. Group I Written Notice, issued October 10, 2002.
[6] Agency Exhibit 8. Group I Written Notice, issued April 3, 2003.
[7] Agency Exhibit 8. Notice of Improvement Needed/Substandard Performance, signed January 20, 2004.
[8] Agency Exhibit 5. Section 715-7.7A, Institutional Operating Procedure (IOP) 715, *Pharmacy*, July 5, 2000.
[9] Agency Exhibit 5. Section 715-7.13, *Ibid.*

promulgated a division operating procedure that provides that no offender will be taken off any prescription medication until seen by the physician.[10]

On February 18, 2004, grievant was assigned to process inmates who had just arrived at the facility. Specifically, grievant was to record pertinent inmate data, including current medications, on an Intrasystem Transfer Medical Review form (ITMR). Patient 1 had been transferred to the facility from a city jail, which forwarded to the facility a Medical Transfer Comments form containing a list of nine medications the inmate was currently taking. The routine procedure requires that grievant record the medications on the ITMR form and on a Medication Administration Record (MAR). Grievant recorded on the ITMR form only four of the nine medications being taken by the inmate; she added one medication that does not appear on the Transfer form. On the MAR form, grievant recorded five of the nine medications and again added one medication that is not on the Transfer form.[11]

Patient 2 also arrived as a transfer from a city jail; his Medical Transfer form states that he is not currently taking any medications. Grievant filled out his ITMR form and listed two medications that the inmate does not need or take.[12] When the errors were discovered the following day, grievant was required to explain her errors on medication error reports for both patients. She stated that the paperwork had gotten mixed up and that it was a confusing day because she had to answer questions from a newly transferred RN.

At 8:10 p.m. on February 14, 2004, Patient 3, who is diabetic, asked a corrections officer to see a nurse in order to check his sugar level. The corrections officer called grievant who told the officer that the inmate could wait until 8:45 p.m. Diabetic inmates are routinely brought to the nurse at 8:45 p.m. for blood glucose testing. Grievant advised the officer to tell the inmate to eat something in the interim. The corrections officer did not tell grievant that the inmate was experiencing any symptoms of hypoglycemia;[13] he said only that the inmate wanted to be tested. At 8:26 p.m., the inmate apparently convinced the corrections officer to allow him to go to the medical department. When he arrived at the medical department, he was not experiencing any symptoms; grievant tested his glucose level at 8:35 p.m. and found it to be low (41).[14] She gave him a tube of liquid glucose and then retested him at 8:45 p.m., and again at 9:03 p.m. to assure that his sugar level was rising satisfactorily.[15]

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[10] Agency Exhibit 6. Section 719.4.C.5, Department of Corrections Division Operating Procedure Number 719, *Medical Transfers*, January 1, 2001.
[11] Agency Exhibit 4.
[12] *Ibid*.
[13] *See* Agency Exhibit 4. Standard Treatment Guidelines for Diabetic Emergencies. Symptoms of hypoglycemia (insulin shock) include shaking, fast pulse, sweating, anxiety, dizziness, impaired vision, weakness, fatigue, headache, or unconsciousness.
[14] The normal blood glucose level ranges between 80 and 120.
[15] Grievant Exhibit 6. Photocopy of liquid glucose package.

On February 19, 2004, the head nurse learned about the three situations described above. She promptly discussed the situations with grievant. On that day, or possibly the next day, grievant wrote a note to the head nurse in which she tacitly acknowledged making the errors and promised to do better.[16]

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. In all other actions, such as claims of retaliation, the employee must present her evidence first and must prove her claim by a preponderance of the evidence.[17]

To establish procedures on Standards of Conduct and Performance for employees of the Commonwealth of Virginia and pursuant to Va. Code § 2.2-1201, the Department of Human Resource Management (DHRM) promulgated Standards of Conduct Policy No. 1.60. 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.

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[16] Agency Exhibit 7. Handwritten, undated note from grievant to head nurse.
[17] §5.8 EDR *Grievance Procedure Manual*, effective July 1, 2001.

Section V.B.3 of the Commonwealth of Virginia's *Department of Personnel and Training Manual* 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.[18] The Department of Corrections (DOC) has promulgated its own Standards of Conduct patterned on the state Standards, but tailored to the unique needs of the Department. Section 5-10.17 of the DOC Standards of Conduct addresses Group III offenses, which are defined identically to the DHRM Standards of Conduct.[19] Gross negligence on the job that results in the escape, death, or serious injury of a ward of the state or the death or serious injury of a state employee is one example of a Group III offense. The offenses listed in the Standards of Conduct are intended to be illustrative, not all-inclusive. Accordingly, an offense that in the judgment of the agency head undermines the effectiveness of the agency's activities or the employee's performance should be treated consistent with the provisions of the Standards of Conduct.[20]

Grievant argues that the agency's case should fail because no one was injured as a consequence of grievant's actions. Grievant's argument is not persuasive because the agency did not charge grievant with causing injury. The agency charged grievant with "Gross negligence of medication errors on three separate occasions with three separate inmates." The offense cited in the preceding paragraph is only one example of a Group III offense. The Standards of Conduct policy covers *any offense* if it meets the definition cited above. Therefore, the issues in this case are whether grievant's actions constituted gross negligence, and if so, what the appropriate level of discipline is.

Virginia law recognizes three degrees of negligence, (1) ordinary or simple, (2) gross, (3) willful, wanton and reckless. Ordinary or simple negligence is the failure to use "that degree of care which an ordinarily prudent person would exercise under the same or similar circumstances to avoid injury to another." *Griffin v. Shively*, 227 Va. 317, 321, 315 S.E.2d 212-213, (1984). Gross negligence is defined as "that degree of negligence which shows indifference to others as constitutes an utter disregard of prudence amounting to a complete neglect of the safety of another. It must be such a degree of negligence as would shock fair-minded men although something less than willful recklessness." *Griffin,* 227 Va. 321, 315 S.E.2d 213, quoting *Ferguson v. Ferguson* 212 Va. 86, 92, 181 S.E.2d 648, 653 (1971). "Willful and wanton negligence is acting consciously in disregard of another person's rights or acting with reckless indifference to the consequences, with the individual aware, from his knowledge of existing circumstances and conditions, that his conduct probably would cause

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[18] Grievant Exhibit 5. DHRM Policy No. 1.60, *Standards of Conduct*, effective September 16, 1993.
[19] Agency Exhibit 2. Section 5-10.17, Procedure Number 5-10*, Standards of Conduct,* June 15, 2002.
[20] Agency Exhibit 2. Section 5-10.7.C, *Ibid.*

injury to another." *Griffin*, 227 Va. 321, 315 S.E.2d 214; *Friedman v. Jordan* 166 Va. 65, 68, 134 S.E.186, 187 (1936).

After carefully weighing all of the circumstances of this case, the hearing officer is persuaded that grievant's erroneous transcription of medications for two patients constituted gross negligence. Not only did she fail to record medications listed on the transfer form but she added medications to Patient 1's MAR that had not been prescribed. In the case of Patient 2, who was not receiving any medication, grievant listed two medications that had not been ordered. When one transcribes something as important as medications, the least the grievant could do is compare the completed MAR with the transfer form to assure that she had transcribed the information correctly. Grievant failed to take this simple but prudent step to assure that her work was accurate. These two errors are especially shocking in view of the fact that grievant had been counseled only one month earlier regarding the necessity to assure that her documentation was accurate. After that warning, grievant should have been particularly vigilant to check her own work.

Grievant's handling of Patient 3 does not appear to have been more than simple negligence. The telephone call she received indicated only that the inmate wanted to have his glucose level checked. There was no indication of any symptoms that would suggest the inmate was going into insulin shock. Knowing that she would be seeing the inmate in approximately half an hour, grievant made a judgement that the inmate should eat something to temporarily boost his sugar level until the scheduled testing time. Since the standard treatment is administration of sugar (orange juice or liquid sugar), the suggestion that the inmate eat something with sugar appears to have been a reasonable stopgap measure. (If the corrections officer had told grievant that the inmate was experiencing hypoglycemic symptoms, grievant would have had to take a more immediate, proactive approach.) Grievant could have asked the corrections officer whether the inmate was experiencing any symptoms but she did not do so. It would have been the ordinarily prudent approach to ask this question; grievant's failure to do so was simple negligence.

The Group III offense involving gross negligence includes an important component – that the negligence results in escape, death, or serious injury. The examples provided in the Standards of Conduct do not include the situation of gross negligence without any of the above consequences. In the absence of specific guidelines, it must be presumed that the authors of the policy felt that gross negligence rises to a Group III level only if escape, death, or serious injury occurs. It follows that in the case of gross negligence that does <u>not</u> result in any injury, the offense could be considered lower than Group III. While each case must be decided on its own merits, the circumstances in this case do not support a Group III offense. The totality of the circumstances, however, rises above mere unsatisfactory work. Grievant's offenses squarely fit the definition of a Group II offense – they were more severe in nature than a Group I offense and

are such that an accumulation of two such offenses normally should warrant removal from employment. Accordingly, the most appropriate level of discipline in this case is a Group II Written Notice.

Grievant made much of her contention that she does not know all of the institutional and departmental operating procedures. She provided as evidence an orientation form she signed after the incidents on which she wrote an amendatory note stating, "I don't know all the IOP & DOP's." Whether grievant was totally familiar with every procedure is a red herring. The errors that occurred on February 18, 2004 were not attributable to whether grievant is familiar with any particular procedure. Grievant was supposed to transcribe verbatim medications from one form to another form. This clerical task does not require familiarity with any written procedures; it requires only care and accuracy to assure that all information is transcribed as it appears on the form from which it is copied.

Grievant asserts that she was overworked and that this was a contributing factor in the errors. Grievant failed to present any evidence or witnesses to corroborate her assertion. The agency presented credible testimony that the medical staff is always busy and that the two days at issue herein were no different from other days. The agency avers that none of the other 11 LPNs in the medical department have complained about being overworked; grievant did not rebut the agency's evidence. On February 18, 2004, grievant was working with a registered nurse (RN) who had recently been transferred from another facility. Because of her unfamiliarity with this facility, the RN sporadically asked grievant procedural questions. Grievant suggests that such questions distracted her and could have caused one or both errors.

The head nurse brought the grievant's errors to the attention of the warden but did not report the charge of gross negligence or her removal from employment to any other authority. Grievant asserts that, if the head nurse truly believed that gross negligence occurred she was required by law to report the matter to the Board of Nursing. Grievant cited Va. Code §§ 54.1-2906 and 54.1-2909 which provide that the chief of staff of health care institutions is obligated to report to the appropriate board any disciplinary action resulting from negligent conduct that is likely to cause injury to patients.[21] The statute does not define the term "health care institution" and grievant did not provide any evidence to show that the facility's medical department fits within this definition. However, assuming *arguendo* that the definition includes the agency's medical department,

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[21] Va. Code § 54.1-2906.A provides, in pertinent part: "The chief executive officer and the chief of staff of every hospital or other health care institution in the Commonwealth shall report within 30 days, except as provided in subsection B, to the appropriate board the following information regarding any person licensed by a health regulatory board unless exempted under subsection E:

3. Any disciplinary action, including but not limited to denial or termination of employment, denial or termination of privileges or restriction of privileges, while under investigation or during disciplinary proceedings, taken or begun by the institution as a result of conduct involving intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, professional ethics, professional incompetence, moral turpitude, or substance abuse."

grievant has not proven that the head nurse is equivalent to either a chief executive officer or a chief of staff. The head nurse reports to the warden for administrative matters, and to a physician in the central office for medical matters. It appears more likely than not that either the warden or the central office physician would be considered chief of staff for the purpose intended by the statute. In any case, the failure to report this matter to the Board of Nursing is moot insofar as grievant's conduct is concerned. If there was a failure to report, it does not change the fact that grievant committed the offenses charged.

Although the issue of alleged procedural noncompliance was addressed at the outset of this decision, further comment is warranted. Grievant asserts that she did not receive notice that she might be disciplined. Grievant was notified by an email message that was printed and handed to her on March 1, 2004. The message advised her that she was scheduled to attend a *hearing* on March 5, 2004 at which the topics would include several problems including medication errors. It is common knowledge among employees of this agency that a *hearing*, as the word was used in this context, means a disciplinary hearing. During the disciplinary meeting each of the three medication errors was discussed. Grievant did not request any additional documentation to rebut the charges.

Grievant correctly observes that the Written Notice issued in this case cites an erroneous date of offense (February 17, 2004). In fact, the medication errors occurred on February 14 & 18, 2004. Under some circumstances, citing an incorrect date of offense on a written notice could adversely affect the agency's case.[22] In this instance, the error is not fatal because during the disciplinary hearing the agency provided grievant with sufficient information to identify the dates and three medication errors.

Grievant suggests that mitigating factors exist in this case. Grievant has been employed by the agency for a moderate but not long period of time. However, the relatively small amount of weight that can be accorded to her length of service is substantially outweighed by the aggravating circumstances of her three prior active disciplinary actions. Therefore, on balance, there is no basis for the application of mitigation to further reduce the level of discipline.

It must be noted that even the most lenient adjudicator might consider that the offenses in this case constitute, at the very least, unsatisfactory work performance - a Group I offense. But, even if the disciplinary action were reduced to a Group I Written Notice, the grievant's removal from employment would be upheld because she has accumulated four active written notices.[23]

[22] Agencies should assure that the date of offense is accurately cited on written notices. If two dates were involved, each date should be cited. If the offense occurred over several dates or a longer span of time, the beginning and ending dates should be cited to indicate a span of time.
[23] Agency Exhibit 2. Section 5-10.15.C.2, Procedure Number 5-10, *Standards of Conduct*, June 15, 2002, states: A fourth active written notice should normally result in removal.

DECISION

The decision of the agency is modified.

The Group III Written Notice for gross negligence issued on March 4, 2004 is REDUCED to a Group II Written Notice.

The termination of grievant's employment on March 5, 2004 is hereby UPHELD.

Grievant has not demonstrated that the agency misapplied any policy, procedure, rule, or regulation.

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. Address your request to:

Director
Department of Human Resource Management
101 N 14th St, 12th floor
Richmond, VA 23219

3. If you believe 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. Address your request to:

Director
Department of Employment Dispute Resolution
830 E Main St, Suite 400
Richmond, VA 23219

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.[24] 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.[25]

[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

[24] 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).

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