Issue: Formal Performance Improvement Counseling, 60-day Performance Warning and suspension; Hearing Date: 07/19/04; Decision Issued: 07/20/04; Agency: UVA Health Systems; AHO: David J. Latham, Esq.; Case No. 769

COMMONWEALTH of VIRGINIA

Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case No: 769

Hearing Date:	July 19, 2004
Decision Issued:	July 20, 2004

PROCEDURAL ISSUE

Grievant requested as part of her relief to return to work in the per diem nursing pool. Grievant has been employed by the agency in two separate capacities: 1) as a full-time classified employee in the angiography department and, 2) as a part-time, wage employee in the per diem nursing pool. To access the grievance procedure, an employee must not be listed as exempt from the Virginia Personnel Act.[1] Grievant has access to the grievance procedure regarding employment matters occurring pursuant to her classified employment in the angiography department. However, because grievant is a wage employee compensated on an hourly basis with respect to her part-time employment in the nursing pool, her pool employment is exempt from the Virginia Personnel Act.[2] Therefore, grievant does not have access to the grievance procedure regarding the nursing pool's decision to restrict her employment as a part-time employee.[3]

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[1] §2.3 Department of Employment Dispute Resolution *Grievance Procedure Manual*, effective July 1, 2001.

[2] Va. Code § 2.2-2905.11.

[3] The Coordinator of the per diem nursing pool may employ nurses as he sees fit. He may utilize part-time wage employees by assigning them more hours, fewer hours, or no hours depending upon workloads, funding availability, or other operational criteria. In this case, the per diem pool

APPEARANCES

Grievant
Attorney for Grievant
One witness for Grievant
Nurse Coordinator
Attorney for Agency
Four witnesses for Agency
Observer for Agency

ISSUES

Were the grievant's actions subject to disciplinary action under the agency's Standards of Performance policy? If so, what was the appropriate level of disciplinary action for the conduct at issue?

FINDINGS OF FACT

Grievant filed a timely grievance from a formal performance improvement counseling, 60-day performance warning, and one-day suspension from work.[4] Following failure to resolve the grievance at the third resolution step, the agency head qualified the grievance for a hearing.[5]

The University of Virginia Health System (Hereinafter referred to as "agency") has employed grievant for 12 years as a registered nurse (RN). Grievant had one prior disciplinary action in December 2002 as the result of an error caused by fatigue from working double shifts.[6] She was warned that future failure to comply with working time limitations could result in further discipline up to and including termination of employment.

Standard operating procedure during interventional surgery requires the nurse to record all vital signs and significant events on a Patient Care Flow Sheet at the time the events occur. If the nurse is unable to do so, she should request a technician or other available nurse to record events. If this is not possible, information is to be jotted down and transcribed to the Flow Sheets as soon as practicable.

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management has a long-standing operating criterion that prohibits assigning hours to nurses who have been evaluated on their annual performance appraisal as needing improvement on any performance factor. Grievant was rated "Needs Improvement" on the Decision Making factor in her most recent evaluation. *See* Exhibit 7, Performance Appraisal, December 12, 2003.

[4] Exhibit 1. Formal Performance Improvement Counseling Form, May 25, 2004.

[5] Exhibit 1. Grievance Form A, filed June 3, 2004.

[6] Exhibit 10. Performance Improvement Counseling with 90-day probation, December 31, 2002.

For a number of years, grievant has been employed as a full-time, classified employee but she has also worked extensively as a "PRN"[7] nurse in the per diem nursing pool. Because of the general, on-going shortage of nursing personnel in the Commonwealth, the demand for grievant's services in the nursing pool has been extensive. In the past, she has worked virtually back-to-back shifts, first in the angiography department and then in other units (or vice versa) sometimes resulting in working 20 hours per day. At times, the long hours grievant worked have taken their toll by adversely affecting her performance. In June 2003, grievant had worked a full shift in the emergency room during the night while sick and vomiting. Despite this, she reported for work in the morning in the angiography department and subsequently fell asleep during an angiography procedure. In August 2003, grievant again worked a shift in another department, came to work in angiography, and was falling asleep while caring for a patient in the recovery room. On this occasion the nurse coordinator drove grievant home. Grievant was then verbally counseled not to work per diem shifts before coming to work in the angiography department.

In October 2003, a patient being prepared for an angiographic procedure went into respiratory arrest following grievant's administration of multiple doses of conscious sedation. After the patient was revived, a review of the records revealed that grievant inaccurately documented event times and failed to record procedural outcome monitors in the chart.[8] It was also determined that grievant had worked a 12-hour shift in another department from 3:00 p.m. to 3:00 a.m. the night before reporting to angiography at 7:00 a.m. Grievant was counseled again not to work in other units before working a day shift in the angiography department.

In early December 2003, a similar type of incident occurred. In this case, the patient's blood oxygen saturation level dropped precipitously after grievant's administration of conscious sedation and the angiographic procedure had to be aborted. Grievant altered the dosage documentation in the records making it unclear whether she administered 100, 50, or 150 milligrams of medication.[9] Grievant was again given verbal counseling about her documentation and about waiting too long to begin giving oxygen to the patient.

As a consequence of these two incidents, grievant's supervisor evaluated her decision making as "Needs Improvement" in her annual performance evaluation. She specifically noted grievant's fatigue caused by working other shifts prior to working in angiography, and giving sedation in increments too large for the individual situations.[10]

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[7] *Pro re na'ta* (according as circumstances may require).
[8] Exhibit 4. Patient records, October 10, 2003.
[9] Exhibit 5. Patient records, December 1, 2003.
[10] Exhibit 7. Annual performance appraisal, December 12, 2003.

In late December 2003, a third incident occurred involving a patient going into respiratory distress following grievant's administration of conscious sedation.[11] In this case, grievant's documentation was deficient because grievant recorded question marks instead of recording the patient's oxygen saturation levels.[12] The department has available ear probes that can be used when patients become restless and inadvertently loosen or dislodge the finger probes. The nurse supervisor again counseled grievant following this incident.

As a consequence of these three incidents, and two other incidents involving two different nurses, the department conducted mandatory training for all physicians, nurses, and technicians. This mandatory training, which grievant attended, addressed all aspects of conscious sedation administration including new requirements that oxygen desaturation to less than 90% for more than 90 seconds, change of certain vital signs and, use of reversal agents is to be recorded in the documentation.[13] The training also mandated that nurses not give any sedation unless a physician is present in the operating room.

On May 18, 2004, grievant was assigned a patient who was already oxygen deficient because he was receiving two liters per minute (LPM) of oxygen. His oxygen saturation level was only 84 percent when grievant administered sedation to him at 10:50 a.m. and she doubled his oxygen to four LPM. Five minutes later, she increased his oxygen to six LPM.[14] By 11:00 a.m., the patient's oxygen saturation was still 84 percent and his blood pressure had dropped below normal (120/80) to 89/66. By 11:05 a.m., grievant had placed the patient on 100 percent non-rebreather equipment (the maximum possible oxygen flow that can be administered); the patient was fully awake and alert at this time. Although his blood pressure remained below normal, she gave additional sedation medication to the patient. Within five minutes the patient's blood pressure had dropped precipitously to 71/45 and his oxygen saturation began to fall. By 11:16 a.m., the patient was unresponsive to any stimuli, his oxygen saturation was 80 or below, and it became necessary to call a "code," get help, intubate the patient, and give cardiopulmonary resuscitation.

Before administering the second dose of sedation, grievant told the physician that she intended to give more sedation. She did not tell him that the patient's vital signs were below normal and that she had already increased his oxygen from two to four to six LPM. The physician was busy scrubbing up preparing for the procedure. He did not make any verbal response or nod his head to indicate acquiescence but did look at grievant.[15] It was later determined

[11] Exhibit 6. Patient records, December 29, 2003.
[12] Finger probes are placed on patients undergoing angiographic procedures to provide continuous monitoring of the patient's blood saturation level.
[13] Exhibit 8. Power Point slide presentation of training conducted in February 2004.
[14] Exhibit 9. Patient records, May 18, 2004.
[15] A radiology technician testified that the physician was <u>not</u> in the room when grievant administered sedation to the patient.

that grievant had worked a four-hour shift in another unit with only a 30-minute break before reporting for work in the angiography department at 7:30 a.m. Grievant admitted that, in this case, she documented the Flow Sheet "long after the procedure was complete."[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.[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 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.

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[16] Exhibit 1. Grievant's response to the second-step respondent, June 17, 2004.
[17] § 5.8 EDR *Grievance Procedure Manual*, effective July 1, 2001.

The agency has promulgated a policy that addresses Standards of Performance, which provides for progressive counseling of employees who fail to meet performance expectations.[18] After informal counseling, the policy provides for formal counseling, then a suspension and/or Performance Warning (probation) and ultimately, termination of employment.

The agency has shown that grievant had been involved in three similar errors in the months prior to May 2004, had been working excessively long hours, had been repeatedly counseled about the errors and, had been warned not to work in other units prior to coming to work in the angiography department. On May 18, 2004, grievant worked during part of the night before coming to work and made serious errors involving the over-sedation of a patient. Therefore, the agency has borne the burden of proving, by a preponderance of evidence, that grievant failed to follow the instructions of a supervisor by willfully violating a reasonable safety instruction.

The procedure requires grievant to obtain permission from the physician before administering sedation. Grievant avers that she told the physician that she was going to administer medication and stated in her June 17, 2004 grievance response that "I *felt* he acknowledged me." However, in her testimony during the hearing, grievant admitted that the physician never responded either verbally or by nodding his head. It is possible that the physician misunderstood her, didn't hear her, or thought she was talking to someone else. The fact that the physician looked at her is not an affirmative acquiescence. It is incumbent on grievant to assure that her communication is understood, <u>and</u> that the physician affirmatively agrees, even if only by a nod of the head.

After the incident, the nurse supervisor spoke with both physicians involved in this case; both said that grievant did not discuss the case before giving sedation. A radiology technician who was present in room testified that grievant did not tell the physician that she was going to give sedation because the doctor was not in room when she pushed the medication intravenously into the patient. Grievant could have asked the physician and the other technician to testify on her behalf but did not do so. Accordingly, it must be presumed that their testimony would not have been favorable to grievant. Nonetheless, even if viewed in the light most favorable to grievant (i.e., that she advised the physician before giving sedation), she failed to fully inform him by not telling him about the patient's fragile condition, low blood pressure, and low oxygen saturation level.

Grievant asserted that the May 18, 2004 incident was partially attributable to loose finger probes which caused the oxygen saturation levels to be incorrect. The agency points out that ear probes are available for just such a possibility. Grievant avers that she attempted to find ear probes but could not find them at the time. The agency also notes that grievant did not mention alleged equipment

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[18] Exhibit 3. Policy # 701: *Employee Rights and Responsibilities,* revised July 1, 2003.

difficulty when this incident was initially investigated. It is troubling that grievant said that she would not have given sedation if she believed the oxygen saturation number was accurate. If grievant did not believe she was getting accurate readings, she could not know what the actual reading was, and the true reading could have been even lower than it was. Despite this uncertainty, grievant nevertheless administered the medication. This lack of judgment, whether or not due to fatigue, is unacceptable in such a life and death situation.

Grievant contends that she misunderstood the work restrictions. She claims that she was only prohibited from working a full eight-hour shift prior to coming to work in the angiography department. However, grievant knew, or reasonably should have known, that the intent behind the work restriction was to ensure that grievant was alert and well-rested when she reported for her full-time job. When one works even a four-hour shift during the small hours of the night, takes only a 30-minute break, and then reports for a full day's work, one cannot be fully rested and alert. This is especially important when one is responsible for making decisions that can potentially have fatal consequences for patients. Accordingly, little evidentiary weight is accorded to grievant's contention.

Grievant inferred that she is being scapegoated because the patient died approximately two weeks after the incident. The agency issued the disciplinary action on May 25, 2004 – only one week after the incident, and well before the patient expired. Therefore, there is no evidence to support grievant's assertion that she is a scapegoat.

Grievant points out that the patient was significantly ill at the time of this procedure. He had heart, liver and respiratory problems. She also claims that he had been taken off Lasix two days earlier and that this contributed to a fluid buildup in his lungs which could have exacerbated his respiratory difficulties. The agency did not rebut this testimony and therefore it is presumed to be true. However, the fact that this patient was so fragile is even more reason that grievant should have been especially alert to his vital signs, given minimal sedation, and kept the physician fully apprised of the decreasing blood pressure and oxygen saturation.

DECISION

The decision of the agency is affirmed.

The issuance of formal counseling, imposition of a one-day suspension, and 60-day performance warning on May 25, 2004 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. 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.[19] You must file a notice of appeal with the clerk of the circuit court in the

[19] 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.[20]

[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]

David J. Latham, Esq.
Hearing Officer

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