Issue: Group III Written Notice with termination (patient abuse); Hearing Date: 10/29/03; Decision Issued: 10/30/03; Agency: DMHMRSAS; AHO: David J. Latham, Esq.; Case No. 5837



COMMONWEALTH of VIRGINIA Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case No: 5837

Hearing Date: Decision Issued: October 29, 2003 October 30, 2003

<u>APPEARANCES</u>

Grievant Two witnesses for Grievant Representative for Agency Four witnesses for Agency Observer for EDR

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 abusing a resident.¹ As part of the disciplinary action, grievant was removed from state employment. Following failure of the parties 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") employed grievant as a direct care aide for less than two 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."³ Following her hiring in March 2002, grievant satisfactorily completed preservice training for direct care aides.⁴ She received instruction on nail care, which instructs that nails should never be clipped back into the flesh.⁵ She also passed a competency test for following nail care procedure.⁶ Prior to the incident described below, grievant had successfully trimmed nails on many clients and had never been counseled for trimming them improperly.

Grievant regularly worked second shift (3:00 p.m.–11:00 p.m.). On July 19, 2003, grievant was assigned primary responsibility for four clients including client D. Client D is severely mentally retarded, nonverbal, and nonambulatory.⁷ At about 8:45 p.m., grievant bathed client D and clipped his fingernails and toenails. She inadvertently clipped his left pinky toenail too close. However, there was no bleeding and grievant put him to bed.

At about 11:15 p.m., the charge aides from second and third shift made rounds together. They noticed that client D had spit up on his sheet. The second shift charge aide asked grievant to help her change the sheet.⁸ As they were doing so, they noticed some blood on the sheet and observed that the left pinky toenail was bleeding.⁹ They washed and dried client D's toe, and left a

⁵ Exhibit 8. *Health Care Basics* preservice training manual.

¹ Exhibit 15. Written Notice, issued August 22, 2003.

² Exhibit 14. *Grievance Form A*, filed August 27, 2003.

³ Exhibit 10. Departmental Instruction (DI) 201(RTS)00, *Reporting and Investigating Abuse and Neglect of Clients*, revised April 17, 2000. The definition of abuse is: "Abuse means any act or failure to act by an employee or other person responsible for the care of an individual that was performed or was failed to be performed knowingly, recklessly or intentionally, and that caused or might have caused physical or psychological harm, injury or death to a person receiving care or treatment for mental illness, mental retardation or substance abuse." The definition of neglect is: "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."

⁴ Exhibit 7. Grievant's Preservice Training Grade Sheet for Direct Contact Staff, May 23, 2002.

⁶ Exhibit 9. Competency check-off list, May 13, 2002.

⁷ Exhibit 2. Psychological Evaluation,

⁸ Exhibit 5. Grievant's *Statement Form*, July 22, 2003.

⁹ Exhibit 6. Second shift direct care aide's *Statement Form*, July 22, 2003.

washcloth under his left foot in case there was any further bleeding.¹⁰ They did not report the matter to anyone and did not write either an event report or an interdisciplinary note. At about 12:00 midnight, the third shift charge aide made rounds again and found client D's toe bleeding.¹¹ He notified both the medication aide and the nurse, who instructed him to clean and bandage the toe. He then properly documented the event and reported it to appropriate management people.

Client nails are inspected and, if necessary, trimmed each Saturday night. The record reflects that client D's nails were last previously trimmed on July 12, 2003 – one week prior to the incident at issue herein.¹² There is no evidence that anyone else cut client D's nails between July 12 and the evening of July 19, 2003. There is no evidence that anyone else cut or trimmed client D's nails after grievant cut them, and before photographs were taken on July 21, 2003.

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.

¹⁰ Exhibit 4. Third shift charge aide's *Statement Form,* July 21, 2003.

¹¹ Exhibit 3. Third shift direct care aide's *Statement Form*, July 21, 2003.

¹² Exhibit 17. Client D's Flow Sheet, July 2003.

In disciplinary actions, the agency must show by a preponderance of evidence that the disciplinary action was warranted and appropriate under the circumstances.¹³

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^{1,14} It is expected that a facility director will terminate the employment of an employee found to have abused or neglected a client.¹⁵

The photographic and other evidence demonstrates conclusively that some of client D's nails were cut too short and that the left pinky toenail did bleed. Grievant admits to cutting the nails and, specifically, that she cut the left pinky toenail too short. There is no evidence that anyone else cut client D's nails before or after grievant cut them. The agency acknowledges that cutting a nail too short could occur accidentally, as when a patient moves unexpectedly. If such an accident occurs, the caregiver would not be disciplined if she reports the incident promptly to supervision and the nurse, and documents the incident in an event report and in the interdisciplinary notes. In this case, the agency's conclusion of abuse was based on the fact that grievant *failed to report* that the client's toe was bleeding after it was discovered at about 11:15 p.m.

Grievant avers that the client's toe was not bleeding immediately after she cut it and, therefore, she saw no need to report the incident at that time. The agency presented no contradictory evidence. However, it is undisputed that client D's toe was bleeding approximately two hours later. There is no evidence that there was any intervening event that would have caused the client's toe to bleed. In fact, the client is not ambulatory and was lying in bed for the entire time. Therefore, grievant could reasonably conclude when the bleeding toe was discovered, that the client had an injury that should be reported. It is also reasonable to conclude that, more likely than not, the bleeding was attributable to cutting the nail too short.

¹³ § 5.8, EDR Grievance Procedure Manual, effective July 1, 2001.

¹⁴ Exhibit 12. DHRM Policy No. 1.60, Standards of Conduct, September 16, 1993.

¹⁵ Exhibit 10. Section 201-8, DI 201(RTS)00, *Ibid*.

At this point in time, grievant was obligated to report the incident to a nurse and to document it in the ID notes and event report. Rather than do so, grievant took ineffective measures to stem the bleeding, covered the client, and left work without reporting it to anyone. By a preponderance of evidence, as well as grievant's admission, the agency has demonstrated that grievant did fail to report client D's injury following discovery at 11:15 p.m..

Grievant testified that the other direct care aide had changed client D's sheet by the time grievant came in the room. However, the other direct care aide said when interviewed that the grievant had helped her change the sheet. In addition, grievant stated when interviewed that she had gone to help the other direct care aide. Thus, the initial statements of both grievant and the other aide indicate that grievant assisted the other aide. However, in her testimony, grievant suggests that the other aide managed to change the sheet alone. While the change of sheets itself is not critical in this case, it appears that grievant is attempting to distance herself from any contact with the client.

While client abuse is typically considered to be intentional physical abuse, the agency's policy is much broader in scope and includes any act or *failure to act* performed knowingly, recklessly or intentionally, and that caused physical harm. In this case, when the client's sheet was being changed, grievant knowingly *failed to report* the bleeding; this constitutes abuse under the agency's definition of the term.

DECISION

The disciplinary action of the agency is affirmed.

The Group III Written Notice and the removal of grievant from state employment on August 22, 2003 are hereby UPHELD. The disciplinary action shall remain active pursuant to the guidelines in the Standards of Conduct.

APPEAL RIGHTS

You may file an <u>administrative review</u> 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 <u>judicial review</u> 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 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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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). <u>See also</u> *Virginia Department of Agriculture and Consumer Services v. Tatum*, 2003 Va. App LEXIS 356, which holds that <u>Va. Code</u> § 2.2-3004(B) grants a hearing officer the express power to decide de novo whether to mitigate a disciplinary action and to order reinstatement.

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

Hearing Officer