Issue: Group II Written Notice (failure to follow instructions and/or applicable written policy); Hearing Date: 01/27/06; Decision Issued: 02/03/06; Agency: DMHMRSAS; AHO: Carl Wilson Schmidt, Esq.; Case No. 8247; Outcome: Agency upheld in full.

COMMONWEALTH of VIRGINIA

Department of Employment Dispute Resolution

DIVISION OF HEARINGS

DECISION OF HEARING OFFICER

In re:

Case Number: 8247

Hearing Date: January 27, 2006
Decision Issued: February 3, 2006

PROCEDURAL HISTORY

On October 7, 2005, Grievant was issued a Group II Written Notice of disciplinary action for failure to follow Medical Services Instruction No. 201.43. On October 17, 2005, Grievant timely filed a grievance to challenge the Agency's action. The outcome of the Third Resolution Step was not satisfactory to the Grievant and she requested a hearing. On December 28, 2005, the Department of Employment Dispute Resolution assigned this appeal to the Hearing Officer. On January 27, 2006, a hearing was held at the Agency's regional office.

APPEARANCES

Grievant
Grievant's Representative
Agency Party Designee
Agency Representative
Witnesses

ISSUE

1. Whether Grievant engaged in the behavior described in the Written Notice?

2. Whether the behavior constituted misconduct?

3. Whether the Agency's discipline was consistent with law (e.g., free of unlawful discrimination) and policy (e.g., properly characterized as a Group I, II, or III offense)?

4. Whether there were mitigating circumstances justifying a reduction or removal of the disciplinary action, and if so, whether aggravating circumstances existed that would overcome the mitigating circumstances?

BURDEN OF PROOF

The burden of proof is on the Agency to show by a preponderance of the evidence that its disciplinary action against the Grievant was warranted and appropriate under the circumstances. Grievance Procedure Manual ("GPM") § 5.8. A preponderance of the evidence is evidence which shows that what is sought to be proved is more probable than not. GPM § 9.

FINDINGS OF FACT

After reviewing the evidence presented and observing the demeanor of each witness, the Hearing Officer makes the following findings of fact:

The Department of Mental Health Mental Retardation and Substance Abuse Services employs Grievant as a Registered Nurse at one of its facilities. She has been working for the Agency for approximately 27 years. No evidence of prior active disciplinary action against Grievant was introduced during the hearing.

On any given day, Grievant may be responsible for administering medication to 75 clients. She began working the day shift in February 2005. The Client resides in one of the living units at the Facility.

The Agency has a dentist located at the Facility so that clients can receive dental treatment. Client dental appointments are scheduled in advance. Employees in the dental office and in the living unit are responsible for ensuring clients attend their scheduled appointments. In order to receive dental services, most clients leave their living units and go to the Facility infirmary. Clients receive medication while in the infirmary in order to enable them to receive dental treatment. After a period of time, clients leave the infirmary and go to the dental office where they receive dental treatment.

Some clients become agitated or upset when they have to leave their living units. In order to reduce a client's level of stress, Agency medical staff will provide these clients with sedatives prior to taking them from the living units.

The Client is one of those clients who become agitated when she has to leave her living area. The Client had a dental appointment scheduled for September 30, 2005. On September 22, 2005, the Client's physician wrote an order prescribing medication to be given to the Client at 7 a.m. on September 30, 2005.[1] The medication was to be given prior to the Client leaving the living unit. The requirements of the order were written into the Client's Medical Administration Record (MAR).[2]

On September 30, 2005, Grievant was responsible for setting up the necessary pills for clients to take. She was supposed to read the MAR and select the pills required for the Client and then ensure that the Client consumed the prescribed medication. She overlooked that the Client was to receive medication prior to leaving the living unit that morning.

The Case Manager working in the dental office looked at his schedule for the day and then called Grievant to make sure the Client would reach her appointment on time. He asked Grievant if the Client had received her preliminary sedation so that she could leave the living unit. Grievant said the Client had not received the sedation and did not believe that the Client was supposed to receive sedation at the living unit.[3] After this telephone conversation ended, the Case Manager spoke with another employee in the dental office and asked if the Client was supposed to receive sedation prior to leaving the living area. The employee said that the Client should be sedated. The Case Manager called Grievant again and asked if anything had changed in the Client's treatment and if she was sure the Client was not to be sedated. Grievant said she would call the nurse in the infirmary and find out the answer. Grievant called the infirmary nurse who said that she did not have any record showing that the Client was to be sedated prior to leaving the living unit.

Grievant took the Client and the Client's medical record to the infirmary and then left to perform other duties. The infirmary nurse reviewed the Client's medical records and realized that the Client was supposed to be sedated prior to leaving the living area and then was to receive the customary sedation for all clients once she reached the infirmary.

CONCLUSIONS OF POLICY

[1] Agency Exhibit 5.

[2] The MAR enables the Agency to identify what medications a client should receive and whether those medications have been administered.

[3] Grievant believed the only sedation the Client was supposed to receive was to be administered once the Client reached the infirmary.

Unacceptable behavior is divided into three types of offenses, according to their severity. Group I offenses "include types of behavior least severe in nature but which require correction in the interest of maintaining a productive and well-managed work force." DHRM § 1.60(V)(B).[4] Group II offenses "include acts and behavior which are more severe in nature and are such that an additional Group II offense should normally warrant removal." DHRM § 1.60(V)(B)(2). Group III offenses "include acts and behavior of such a serious nature that a first occurrence should normally warrant removal." DHRM § 1.60(V)(B)(3).

"Failure to follow … established written policy" is a Group II offense.[5] Medical Services Instruction No. 201.43 sets forth the Facility's policy regarding the administration of medications and treatments to clients. Section 1(C) requires"

> (1) All medications must be set up and administered by using the approved [Facility] Medication Record ….
> (2) Each drug must be identified up to the point of administration. All drugs are to be administered in compliance with the MD/FNP's orders and without error. ***
> (5) All medications must be charted by the nurse who administers them.
> (6) Medications are only charted after they are administered and must be charted immediately after administration is completed on a cottage or living area. *** (Emphasis original).

Grievant failed to administer the correct medication to the Client as specified in the Client's Medication Administration Record and in compliance with the Client's physician's order. Grievant failed to comply with Medical Services Instruction No. 201.43.

Grievant argues mitigating circumstances exist because other nurses at the Facility often make similar mistakes, yet they are not disciplined. The Agency presented evidence that its nursing staff may administer approximately 2700 to 2800 medications per day to clients at the Facility. Medication errors occur one or two times per month. This number is low for a facility the size of Grievant's Facility. The Agency understands that "human error" occurs and rarely takes disciplinary action for medication errors. Grievant presented documents confirming that nurses at the Facility make medication errors and asserted without contradiction that those nurses were not disciplined.[6]

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[4] The Department of Human Resource Management ("DHRM") has issued its *Policies and Procedures Manual* setting forth Standards of Conduct for State employees.

[5] DHRM § 1.60(V)(B)(2)(a). The Facility has a similar policy establishing its Standards of Conduct. Failure to comply with written policy is a Group II offense under the Facility's policy.

[6] See Grievant Exhibit 2. Grievant argues that many of these medication errors involved serious consequences to clients. Her medication error, however, only resulted in the Client's dental appointment

Grievant was not disciplined for making a routine medication error. Aggravating circumstances exist in this case. Grievant was questioned twice by the Case Manager about whether the Client should receive sedation prior to leaving the living unit. Grievant should have checked the Client's Medication Administration Record and/or physician's orders to determine what treatment was necessary for the Client. Instead, Grievant called the infirmary nurse. The infirmary nurse did not have the Client's MAR because the MAR stays with the Client. Grievant should have known this. Only after the Client and her MAR were taken to the infirmary could the infirmary nurse determine that the Client needed sedation prior to leaving the living unit. This case involves not merely a medication error, but a medication error that was identified by other staff as a possibility and then again overlooked by Grievant. To the extent mitigating circumstances exist in this case, those circumstances are negated by aggravating circumstances.

Grievant argues that Facility Policy 8.7, Sedation Administration for Procedures requires sedation in the infirmary only. This policy provides, "[r]esidents will be transported to the Infirmary to receive sedation and sedation monitoring 45 minutes before the appointment for the procedure or as ordered. They are not to be brought any earlier." Grievant's argument is not supported by this policy. It does not prohibit additional sedation prior to having a client leave a living unit. In addition, Grievant's physician's orders would override any policy to the contrary.

DECISION

For the reasons stated herein, the Agency's issuance to the Grievant of a Group II Written Notice of disciplinary action is **upheld**.

APPEAL RIGHTS

You may file an administrative review request within **15 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. Please address your request to:

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having to be re-scheduled. Grievant was not disciplined solely for making a medication error. The severity of the error was not of significance – the preventability of the error was of significance.

Director
Department of Human Resource Management
101 North 14th St., 12th Floor
Richmond, VA 23219

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. Please address your request to:

Director
Department of Employment Dispute Resolution
830 East Main St. STE 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 15 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 15-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. 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.[7]

[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].

S/Carl Wilson Schmidt

Carl Wilson Schmidt, Esq.
Hearing Officer

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