COMMONWEALTH of VIRGINIA

Department of Human Resource Management

OFFICE OF EMPLOYMENT DISPUTE RESOLUTION

DECISION OF HEARING OFFICER

In re:

Case Number: 11659

Hearing Date: May 21, 2021
Decision Issued: June 10, 2021

PROCEDURAL HISTORY

On January 11, 2021, Grievant was issued a Group III Written Notice of disciplinary action with removal for client neglect.

On January 27, 2021, Grievant timely filed a grievance to challenge the Agency's action. The matter advanced to hearing. On February 22, 2021, the Office of Employment Dispute Resolution assigned this appeal to the Hearing Officer. On May 21, 2021, a hearing was held by remote conference.

APPEARANCES

Grievant
Agency Representative
Witnesses

ISSUES

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. The employee has the burden of raising and establishing any affirmative defenses to discipline and any evidence of mitigating circumstances related to discipline. 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 Behavioral Health and Developmental Services employed Grievant as a Direct Service Associate II at one of its locations. She had been employed by the Agency from 1992 to 2008. Grievant returned to the Agency in 2018.

Grievant had prior active disciplinary action. On December 18, 2020, Grievant received a Group II Written Notice for failure to follow policy.

Patient 1 was a 40 year old female admitted to the Facility on April 30, 2015. Her diagnosis was schizoaffective disorder, bipolar type. She sometimes heard voices telling her to hurt others and herself. She was sometimes impulsive. She sometimes threw her meal tray and broke drawers in her room. She sometimes required medication and restraints to be able to calm down.

Patient 1 resided in a room that opened into a Common Area where other residents could assemble. The Common Area connected through a hallway to a Day Room. The Day Room was much larger than the Common Area and had a Laundry Room and Nursing Stations. One hallway extended from the Day Room into a Laundry Room. Another hallway extended from the Day Room to several rooms including a Quiet Room. Facility staff would sometimes place agitated or aggressive patients in the Quiet Room to allow them to calm down.

On December 6, 2020, Grievant was working at the Facility. Grievant was seated working in the Nursing Station when Patient 1 approached the window to the Nursing Station and asked Grievant if Patient 1 could do her laundry. Patient 1 was told she could do her laundry when the next shift of employees arrived at the Facility because Grievant's shift was nearing the end of their shift. Patient 1 became irate and began following Grievant into the Laundry Room. Patient 1 approached Grievant and swung at Grievant knocking Grievant's glasses of and bruising Grievant's eye.

Patient 1 ran from the Laundry Room into the Day Room and then down a hallway to a Common Area and into her room. Patient 1 yelled and screamed while she was in her room.

The RN concluded that Patient 1 should be placed in restraints and moved to the Quiet Room because Patient 1 had a history of going to her room and then leaving her room to engage in further misbehavior. The Nurse wheeled the Emergency Restraint Chair (ERC) to the front of Patient 1's room. The Nurse asked Patient 1 to come out of her room and get into the ERC. Grievant and DSA 1 approached the room as Patient 1 came out. Patient 1 pointed at Grievant and indicated she did not want Grievant there. DSA 2 also approached the room. Grievant backed up a few feet and Patient 1 exited her room and sat in the ERC. DSA 1 began wrapping the restraint over Patient 1's left side. The Nurse began wrapping the restraint over Patient 1's right side. DSA 2 kneeled behind the chair and began wrapping Patient 1's legs in restraints from behind. Grievant stood behind DSA 2 and watched the three employees attach restraints. Grievant was ready to provide assistance if staff needed assistance.

Patient 2 and Patient 3 entered the Common Area and approached the ERC from behind and to Grievant's left. Grievant did not notice the two patients approaching. Patient 2 reached over DSA 2 and hit Patient 1 on the top of her head. Grievant used her left arm to move Patient 2 back to stop the hitting. Patient 2 left the Common Area and walked through a hall to the Day Room. Grievant asked Patient 3 to leave and Patient 3 left the Common Area, walked down a hallway into the Day Room.

Patient 4 entered the Common Area and walked to a couch and laid down. DSA 1 began talking to Grievant. Patient 3 returned to the Common Area and approached the ERC in an attempt to hit Patient 1. DSA 2 used her body to block Patient 3. Grievant tried to pull Patient 3 away from Patient 1 but Patient 3 was able to hit Patient 1 on the top of her head. Patient 2 returned to the Common Area and Grievant confronted her and turned her around so that she could leave. As Grievant was attempting to escort Patient 2 and other patients out of the Common Area, Patient 4 stood up from the couch and walked behind Grievant towards the ERC. Patient 4 hit Patient 1 on the top of her head. DSA 1 and DSA 2 redirected Patient 4 out of the Common Area.

The Nurse pushed the ERC with Patient 1 in the chair out of the Common Area and into a hallway connecting to the Day Room. Patient 4 and other patients were in the Day Room. As the ERC approached the Day Room, Patient 4 raised and shook her fists at Patient 1 in order to threatened Patient 1. Other patients also began shaking their

hands and fists. Grievant and DSA 2 were ahead of the Nurse and gestured to the patients in the Day Room to move back. The patients disbursed. The Nurse pushed the ERC into the Day Room and then down another hallway towards the Quiet Room. Grievant and DSA 1 followed behind the Nurse.

Grievant returned to the Day Room from the hallway and began walking directly to Patient 4. Patient 4 was in the middle of the Day Room and talking loudly. Grievant was attempting to address Patient 4's misbehavior. Once Grievant was past the opening of the hallway containing the Quiet Room, Patient 5 walked past Grievant and into the hallway. Patient 3 also quickly walked into the hallway. Grievant did not notice that Patient 5 and Patient 3 had entered the hallway. These patients walked down to where the Nurse was trying to move the ERC into the Quiet Room. They attempted to reach over the Nurse in order to hit Patient 1. The Nurse pushed Patient 3 away and Patient 3 began walking down the hallway towards the Day Room. The Nurse tried to push Patient 5 away, but Patient 5 began fighting with the Nurse. DSA 1 came out of the Quiet Room to begin helping the Nurse.

While Grievant continued to speak with Patient 4, Patient 3 walked out of the hallway back into the Day Room. As Patient 3 walked past Grievant, Grievant turned and looked down into the hallway and observed the conflict. Grievant began running out of the Day Room and into the hallway. Grievant helped move Patient 5 away from the Nurse and directed her down the hallway towards the Day Room. DSA 1 finished pushing the ERC into the Quiet Room.

The Nurse exited the hallway into the Day Room and then went into the Nursing station. Grievant walked out of the hallway into the Day Room.

Patient 1 remained in the ERC for two hours. Patient 1 did not receive any major injuries from being hit on the head.

CONCLUSIONS OF POLICY

The Agency has a duty to the public to provide its clients with a safe and secure environment. It has zero tolerance for acts of abuse or neglect and these acts are punished severely. Departmental Instruction ("DI") 201 defines Neglect as:

> The failure by an individual, program, or facility operated, licensed, or funded by the department responsible for providing services to do so, including 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.

"[U]nsatisfactory work performance" is a Group I offense.[1] In order to prove unsatisfactory work performance, the Agency must establish that Grievant was

[1] See Attachment A, DHRM Policy 1.60.

responsible for performing certain duties and that Grievant failed to perform those duties. This is not a difficult standard to meet.

The Agency alleged Grievant failed to provide services necessary for the health, safety, and welfare of Patient 1 because Grievant did not fully watch out for and protect Patient 1. Patient 1 was receiving mental health treatment at the Facility.

The Agency alleged Grievant should have discontinued interacting with Patient 1 after Patient 1 hit Grievant in the Laundry Room. Although this may have been true, it is not client neglect. If Grievant had withdrawn from further interaction with Patient 1, Grievant could not have provided any barrier to the attacks on Patient 1 by other patients. Thus, the attacks on Patient 1 would have been worse had Grievant not followed staff to Patient 1's room.

The Agency alleged Grievant failed to block patients and because of this they were able to reach and hit Patient 1. Grievant reported to the Nurse. The Nurse did not instruct Grievant to serve as a look-out or to block patients from approaching Patient 1. The Agency did not establish that patients routinely attacked Patient 1 and that Grievant should have been aware prior to this date that patient attacks on Patient 1 would be likely.

The Agency alleged that when Grievant was in front of Patient 1's room, the Nurse had to tell Grievant to back up several times until Grievant did so. The video shows Grievant backing up when instructed to do so. Whether Grievant backed up quickly enough would not justify a finding of neglect. Ultimately, Grievant backed up and Patient 1 came out of her room and sat in the ERC chair.

The Agency alleged Grievant engaged in neglect because Patient 2 and Patient 3 were able to hit Patient 1 on the head. The evidence showed that Grievant had not been instructed be a look-out and that the two patients approached Patient 1 without Grievant noticing them because she was focused on helping staff restrain Patient 1. Grievant did not engage in client neglect merely because she did not anticipate initially that two patients would attempt to hit Patient 1.

The Agency alleged Grievant engaged in neglect because Patient 4 was able to hit Patient 1 on the head. The evidence showed that Grievant had not been instructed to serve as a look-out and was escorting other patients out of the Common Area in order to protect Patient 1. Grievant is not responsible for failing to anticipate that Patient 4 would get off the couch and walk behind Grievant in order to hit Patient 1. Grievant did not engage in client neglect because Patient 4 was able to hit Patient 1.

The Agency alleged Grievant engaged in neglect because she walked away from the Nurse who was putting Patient 1 into the Quiet Room and down the hallway into the middle of the Day Room. Once Grievant was in the Day Room she walked to Patient 4 and began discussing Patient 4's inappropriate behavior. While focused on Patient 4,

Patient 5 and Patient 3 walked into the hallway and down to where the Nurse was attempting to put Patient 1 into the Quiet Room.

Grievant's action of speaking with Patient 4 was not client neglect of Patient 1. Grievant was focused on providing care to Patient 4. Grievant was no longer providing direct care to Patient 1. It was appropriate for Grievant to speak with Patient 4 because Patient 4 had raised her arms and made fists to threaten Patient 1. On the other hand, once Patient 4 raised her fists to signal a threat, other patients in the Day Room acted similarly. Grievant should have recognized that the other patients remained a risk of threatening Patient 1. At this point, Grievant had witnessed several patients hit Patient 1 and observed several patients raise their hands to make fists to threaten Patient 1. Grievant should have recognized there was a risk of patients running down the hallway to threaten Patient 1. Grievant's behavior was unsatisfactory work performance. In short, Grievant did not engage in client neglect and did not violate the Agency's DI 201. Grievant engaged in unsatisfactory work performance.

In rare circumstances, a Group I may constitute a Group II where the agency can show that a particular offense had an unusual and truly material adverse impact on the agency. Should any such elevated disciplinary action be challenged through the grievance procedure, management will be required to establish its legitimate, material business reason(s) for elevating the discipline above the levels set forth in Attachment A, DHRM Policy 1.60.

The Agency has established an unusual and material adverse impact because Grievant focused on Patient 4 while remaining at the end of the hallway. Two patients were able to walk past Grievant into the hallway and confront the Nurse which led to the Nurse and a patient fighting. Accordingly, the Agency has presented sufficient evidence to support the issuance of a Group II Written Notice for unsatisfactory work performance.

Upon the accumulation of two Group II Written Notices, an agency may remove an employee. Grievant as accumulated two Group II Written Notices. The Agency's decision to remove Grievant must be upheld.

Grievant argued that the Nurse should have called an emergency code sooner which would have summonsed additional staff immediately. Although the Nurse could have called a code sooner, she did not do so. Grievant was responsible for acting in a manner consistent with the environment she faced which was one without additional staff responding to an emergency.

Va. Code § 2.2-3005.1 authorizes Hearing Officers to order appropriate remedies including "mitigation or reduction of the agency disciplinary action." Mitigation must be "in accordance with rules established by the Department of Human Resource Management …."[2] Under the *Rules for Conducting Grievance Hearings,* "[a] hearing officer must give deference to the agency's consideration and assessment of any mitigating and

[2] Va. Code § 2.2-3005.

aggravating circumstances. Thus, a hearing officer may mitigate the agency's discipline only if, under the record evidence, the agency's discipline exceeds the limits of reasonableness. If the hearing officer mitigates the agency's discipline, the hearing officer shall state in the hearing decision the basis for mitigation." A non-exclusive list of examples includes whether (1) the employee received adequate notice of the existence of the rule that the employee is accused of violating, (2) the agency has consistently applied disciplinary action among similarly situated employees, and (3) the disciplinary action was free of improper motive. In light of this standard, the Hearing Officer finds no mitigating circumstances exist to reduce the disciplinary action.

DECISION

For the reasons stated herein, the Agency's issuance to the Grievant of a Group III Written Notice of disciplinary action is **reduced** to a Group II Written Notice. Grievant's removal is **upheld** based on the accumulation of disciplinary action. The Agency is **Ordered** to revise its disciplinary records to reflect that Grievant was not removed from employment based on client neglect.

APPEAL RIGHTS

You may request an administrative review by EDR within **15 calendar** days from the date the decision was issued. Your request must be in writing and must be **received** by EDR within 15 calendar days of the date the decision was issued.

Please address your request to:

Office of Employment Dispute Resolution
Department of Human Resource Management
101 North 14th St., 12th Floor
Richmond, VA 23219

or, send by e-mail to EDR@dhrm.virginia.gov, or by fax to (804) 786-1606.

You must also provide a copy of your appeal to the other party and the hearing officer. The hearing officer's **decision becomes final** when the 15-calendar day period has expired, or when requests for administrative review have been decided.

A challenge that the hearing decision is inconsistent with state or agency policy must refer to a particular mandate in state or agency policy with which the hearing decision is not in compliance. A challenge that the hearing decision is not in compliance with the grievance procedure, or a request to present newly discovered evidence, must refer to a specific requirement of the grievance procedure with which the hearing decision is not in compliance.

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.[1]

[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

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