Issue: Group III Written Notice with Termination (client neglect, unsatisfactory performance, and failure to follow policy); Hearing Date: 06/18/13; Decision Issued: 06/25/13; Agency: DVS; AHO: Carl Wilson Schmidt, Esq.; Case No. 10097; Outcome: No Relief – Agency Upheld.

COMMONWEALTH of VIRGINIA

Department of Human Resource Management

OFFICE OF EMPLOYMENT DISPUTE RESOLUTION

DECISION OF HEARING OFFICER

In re:

Case Number: 10097

Hearing Date: June 18, 2013
Decision Issued: June 25, 2013

PROCEDURAL HISTORY

On March 28, 2013, Grievant was issued a Group III with removal Written Notice of disciplinary action for unsatisfactory performance, failure to follow policy, violation of safety rules, and client abuse.

On April 24, 2013, Grievant timely filed a grievance to challenge the Agency's action. The matter proceeded to hearing. On May 13, 2013, the Office of Employment Dispute Resolution assigned this appeal to the Hearing Officer. The Hearing Officer found just cause to extend the time frame to issue a decision in this hearing due to the unavailability of a party. On June 18, 2013, a hearing was held at the Agency's office.

APPEARANCES

Grievant
Grievant's Counsel
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. 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 Veteran Services employed Grievant as a LPN Charge Nurse. She worked for the Agency from August 10, 2008 until her removal effective April 26, 2013. The purpose of her position was:

> The Licensed Practical Nurse is responsible for providing direct nursing care to residents during their shifts and for maintaining the quality of services to fulfill the objective of the facility in accordance with the policies and procedures set forth by the facility administration and established nursing standards. The LPN may monitor and supervise the direct care staff in the performance of their duties.[1]

Grievant had prior active disciplinary action consisting of a Group I Written Notice for tardiness.

Grievant received training regarding the Agency's Abuse Prevention policy. She also received training regarding "Understanding Bloodborne Pathogens." As part of her training regarding blood-borne pathogens, Grievant learned that the Agency considered the presence of blood to require standard precautions to protect clients and employees from contracting infections and pathogens.

[1] Agency Exhibit 4.

Medication pass is the process of administering medications to residents. A nurse uses a medication cart holding medication for each patient and then dispenses the medication to each patient after verifying the appropriate dose. Medication pass usually begins at 8 p.m. and ends at 10 p.m.

Resident 1 was a patient at the Facility. He became ill on March 15, 2013 and his condition had not improved by March 17, 2013. He had a temperature and was warm to the touch.

Resident 2 was a patient at the Facility. He resided in the room next to Resident 1. He often did not wear his shirt while in his room. He used a wheelchair.

On March 17, 2013, Grievant was working as the Charge Nurse from 3 p.m. to 11 p.m. at the Agency's Facility. She was responsible for supervising CNA M and CNA R. Grievant reported to the Supervisor who was in charge of the entire Facility.

CNA M took his 30 minute meal break beginning at 8 p.m. or 8:30 p.m. He left the unit. CNA R "covered" for CNA M in his absence. Resident 1's Daughter was in her father's room and observed that he was warm and possibly ill. She asked Grievant to take Resident 1's temperature. Grievant was in the process of passing medication with her medication cart. Grievant told the Daughter she would have some else take the temperature. When CNA R walked near Grievant, Grievant asked CNA R to take Resident 1's temperature. CNA R took Resident 1's axillary temperature. Resident 1's temperature was approximately 98 degrees which CNA R concluded was within the normal range. CNA R told Grievant the temperature of Resident 1. Grievant concluded it was unnecessary to give Resident 1 medicine because his temperature was within a normal range for that patient.

After CNA M returned from his meal break, he heard Resident 2 calling for help. CNA M went to Resident 2's room and observed Resident 2 with an open wound and blood running down his arm. Resident 2 was not wearing a shirt because he was in his room. CNA M told Resident 2 to "hold on" and he would go get a nurse.[2] CNA M walked approximately 120 feet from Resident 2's room to find Grievant. Grievant was working at her medication cart near the nursing station. CNA M told Grievant that Resident 2 was "bleeding pretty bad" on his arm and needed to have it "looked at and taken care of." Grievant told CNA M that she would go to Resident 2 as soon as she had time to get to him. Grievant continued to work with her medication cart and took no action to assist Resident 2. After approximately ten minutes, Resident 2 remained in his room and yelled down the hallway to Grievant that his arm was still bleeding and he needed care. Grievant told Resident 2 to come to her. Resident 2 wheeled his chair approximately 120 feet to reach Grievant. His arm was bleeding as he wheeled himself to Grievant. Grievant observed Resident 2's wound and then cleaned and dressed the wound. Grievant did not document her treatment of Resident 2's wound.

[2] Dressing wounds was not a treatment within CNA M's scope of practice.

Grievant was concerned about her interaction with the Daughter so she asked another Charge Nurse to call the Supervisor to come to Grievant's unit. At approximately 9:15 p.m. or 9:30 p.m., the Supervisor went to the unit and spoke with Grievant. Grievant explained about her interaction with the Daughter and expressed frustration in addressing the Daughter's concerns.

The Supervisor spoke with the Daughter and learned that the Daughter did not feel that Resident 1 was safe when he was left in Grievant's care. The Daughter told the Supervisor that she went to Grievant three times to have Grievant take her father's temperature but Grievant did not do so.

At approximately 10:10 p.m., the Supervisor took Resident 1's axillary temperature and determined that it was 99 degrees. Because the temperature was axillary and not an oral temperature, the Supervisor concluded Resident 1's oral temperature was 100 or 101 degrees and was a low grade temperature. At approximately 10:18 p.m., the Supervisor gave acetaminophen to Resident 1. She dispensed the drug for pain relief.

CONCLUSIONS OF POLICY

Unacceptable behavior is divided into three types of offenses, according to their severity. Group I offenses "include acts of minor misconduct that require formal disciplinary action."[3] Group II offenses "include acts of misconduct of a more serious and/or repeat nature that require formal disciplinary action." Group III offenses "include acts of misconduct of such a severe nature that a first occurrence normally should warrant termination."

[A]buse or neglect of clients" is a Group III offense.[4]

The Agency has a Standard Precautions Policy to prevent the spread and transmission of infection within the facility. The policy provides:

> It is the intent of this facility that: 1) all resident blood, body fluids, excretions and secretions other than sweat will be considered as potentially infectious; 2) Standard (Universal) Precautions are indicated and will be utilized for all residents.
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[3] The Department of Human Resource Management ("DHRM") has issued its Policies and Procedures Manual setting forth Standards of Conduct for State employees.

[4] See, Attachment A, DHRM Policy 1.60.

> If the resident leaves the room, precaution should be maintained to minimize the risk of transmission of microorganisms to other residents and contamination of environmental surfaces or equipment.[5]

The Agency has an Abuse Prevention policy to "ensure the safety of all residents."[6] Under this policy, "abuse" is defined as:

> Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. This presumes [sic] that instances of abuse of all residents, even those in a coma, caused by physical harm, or pain or mental anguish.

"Neglect" is defined as:

> Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish were mental illness.

The Hearing Officer interprets the Agency's policy to define abuse and neglect to include circumstances in which a client receives services but only after an unreasonable delay. The service at issue for Resident 1 was having his temperature taken. The service at issue for Resident 2 was having his wound examined and dressed.

The Agency has not established that Grievant engaged in client abuse or neglect with respect to Resident 1. The Agency alleged that Grievant failed to take the temperature of Resident 1 and that the Supervisor did so several hours after the Daughter's first request. The evidence showed Grievant was approached by the Daughter and asked her to take Resident 1's temperature. Since Grievant was involved in her med pass, she asked CNA R to take the Resident 1's temperature. The Agency has not established that the length of time between the Daughter's request and the taking of the temperature was too long. Indeed, it appears that shortly after the Daughter asked Grievant to take Resident 1's temperature, CNA R took Resident 1's temperature and reported that information to Grievant. The Agency has not established that Grievant's failure to give acetaminophen to Resident 1 was inappropriate. Grievant established that based on Resident 1's temperature history, an axillary temperature of approximately 98 degree was not unusual for Resident 1.

The Agency has established that Grievant engaged in client abuse or neglect with respect to Resident 2. Resident 2 had an open wound with blood dripping down his arm. The Agency's policy was to treat blood as potentially infectious. The Agency's

[5] Agency Exhibit 7.

[6] Agency Exhibit 10.

policy was to minimize the risk of transmission of microorganisms to other residents, other services, or equipment. The Agency expected Grievant to respond to Resident 2 with a sense of urgency. Even though Grievant knew that Resident 2's wound was bleeding, she disregarded his concerns and continued to work on other matters. After approximately ten minutes, Resident 2 called for Grievant's help. If Resident 2 had not yelled to Grievant, it is not clear when or if she would have provided assistance to Resident 2. Once Resident 2 got Grievant's attention, she instructed him to come to her. He used his arms to wheel himself through the hallway approximately 120 feet to Grievant's location. Resident 2 had an open wound. Grievant placed him at risk of exacerbating his would by requiring him to use his arms. The Agency considered blood as potentially infectious. Resident 2 could have bled on the carpet as he wheeled himself to Grievant. This could have placed other employees and residents at risk of contamination from walking on the carpet in the hallway. Grievant's failure to timely respond to the needs of Resident 2 amounted to a deprivation of services that were necessary to attain or maintain Resident 2's physical well-being. The Agency has presented sufficient evidence to support the issuance of a Group III Written Notice. Upon the issuance of a Group III Written Notice, an agency may remove an employee. Accordingly, Grievant's removal must be upheld.

Grievant argued that Resident 2's wound was a reopening of an existing wound and not a new wound. The outcome of this case is not affected by whether Resident 2's wound was a new or existing wound.

Grievant argued that she walked towards Resident 2, met him at his room and then pushed him to where she had been working. Based on the credible testimony of CNA M, the Agency has presented sufficient evidence to show that Grievant asked Resident 2 to come to her location and that he did so. Moreover, had Grievant walked to Resident 2's room, she could have taken her medical supplies and treated the wound in Resident 2's room. Given that Resident 2 was not wearing his shirt, Grievant would have known to treat him in his room to preserve his dignity as required under the Agency's policies.

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 …."[7] Under the *Rules for Conducting Grievance Hearings,* "[a] hearing officer must give deference to the agency's consideration and assessment of any mitigating and 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

[7] Va. Code § 2.2-3005.

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 with removal 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 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:

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

   or, send by fax to (804) 371-7401, or e-mail.

2. If you believe that the hearing decision does not comply with the grievance procedure or if you have new evidence that could not have been discovered before the hearing, you may request that EDR 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:

   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 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 provide a copy of all of your appeals to the other party, EDR, 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.

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.[8]

[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

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Carl Wilson Schmidt, Esq.
Hearing Officer

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