Issue: Group III Written Notice with Termination (patient abuse); Hearing Date: 07/01/13; Decision Issued: 07/16/13; Agency: DBHDS; AHO: Lorin A. Costanzo, Esq.; Case No. 10119; Outcome: No Relief – Agency Upheld.

COMMONWEALTH OF VIRGINIA
OFFICE OF EMPLOYMENT DISPUTE RESOLUTION

DECISION OF HEARING OFFICER

In the matter of: Grievance Case No. 10119

Hearing Date: July 1, 2013
Decision Issued: July 16, 2013

PROCEDURAL HISTORY

Grievant was issued a Group III Written Notice on May 17, 2013 (offense date 4/8/13) with removal effective 5/17/13 for, "Positive finding of physical abuse according to DI 201, reporting and investigating abuse and neglect of clients. ….". [1]

Grievant timely grieved the issuance of the Group III Written Notice with termination.[2] The matter was qualified for a hearing and, effective 6/17/13, a hearing officer was appointed by the Department of Human Resources Management, Office of Employment Dispute Resolution.[3] On June 20, 2013 a prehearing telephone conference call was held with Grievant and Agency Advocate. The grievance hearing was set, by agreement, for July 1, 2013 at 9:00 A.M. at Facility.

Exhibits… Grievant presented a three ring binder of exhibits containing 4 color coded tabs. Agency presented a three ring binder of exhibits tabbed 1 through 13. By agreement of the parties, all exhibits offered by each party were admitted *en-masse.* At hearing, by agreement, exhibits designated as "HO 1 ("A & B)" and "HO 2" were also admitted.

Hearing… Hearing was held on July 1, 2013 beginning at 9:00 A.M. at Facility.

APPEARANCES

Grievant (who was a witness)
Agency's Presenter (who was also Agency party designee)
Other Witnesses: Investigator
Security Officer
PNA-1
PNA-2
Facility Director
Nurse Director

ISSUES

[1] A. Tab 2, Written Notice.
[2] A. Tab 2.
[3] A. Tab 1.

Whether the issuance of a Group III Written Notice with termination was warranted and appropriate under the 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. A preponderance of the evidence is evidence which shows that what is intended to be proved is more likely than not; evidence more convincing than the opposing evidence.[4]

The employee has the burden of raising and establishing any affirmative defenses to discipline and any evidence of mitigating circumstances related to discipline.[5]

FINDINGS OF FACT

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

01. Facility is a psychiatric hospital operated by Agency which provides inpatient psychiatric treatment for adults. [6]

02. Grievant is Registered Nurse who has been employed by Facility as a since 4/25/12.[7]

03. Patient is an adult female who has been a receiving care and treatment for a mental illness at Facility since 2010. Patient has a history of severe psychosis, delusions, and hallucinations. Patient has suffered chronic mental illness with prolonged hospitalizations. She has a history of aggression when grossly psychotic and a history of extremely poor self-care when grossly psychotic.[8]

04. Patient has a long history of refusal of medications and a long history of resistive, uncooperative, and combative behaviors when given medications, especially when given IM injections or certain procedures related lab work.[9]

05. On April 8, 2013 at about 12:30 A.M./1:00 A.M. Patient was in her room, yelling, and crying. Her roommate was getting upset. PNA-2 stayed with Patient while PNA-1 went to advise Grievant of the situation. After advising Grievant, staff walked with Patient to the dayroom.[10]

06. After being informed of the situation, Grievant made the decision to give Patient an Intramuscular ("IM") injection of Ativan and called Facility Security for assistance. Security Officer responded and met with Grievant in the Nursing Office. Grievant told Security Officer that Patient was going to get an IM over

[4] Dept. of Employment Dispute Resolution, *Grievance Procedure Manual*, §5.8 and §9.
[5] *Grievance Procedure Manual,* Office of Employment Dispute Resolution, Dept. of Human Resources Management, §5.8 *Rules for the Hearing*.
[6] A. Tab 4, Document 13.
[7] A. Tab 2.
[8] A. Tab 3, Document 3.
[9] A. Tabs 3 & 4 and Testimony.
[10] A. Tab 4.

objection to try to calm her down. Both exited to the female dayroom where Patient was sitting with PNA-1 and PNA-2 in attendance. Grievant stated "Ready" or "Are you ready?". Hearing this, PNA-1 and PNA-2 got Patient standing up and starting to walk. Patient was between PNA-1 and PNA-2. Security Officer was behind a PNA. [11]

07. Security Officer, PNA-1, and PNA-2 believed Patient, who was standing up and walking, was going to be escorted to either the open seclusion room or her bed area and receive an IM injection of Ativan at that location. However, before Patient had taken more than a couple of steps, Grievant pulled down Patient's pants exposing an IM injection site on her left hip and gave her the IM injection in the dayroom while Patient was standing.

08. Patient was not informed she was getting an IM injection. Patient was not offered an oral dose of Ativan.

09. None of the other staff in the dayroom were informed or were expecting Patient was to be given the IM injection in the dayroom or that she would be given the injection while standing and beginning to walk.[12]

10. Patient started to go to the floor upon her pants being pulled down and a needle being inserted. PNA-1, PNA-2, and Security Officer had to unexpectedly grab Patient to prevent her falling directly on the floor and possibly hurting herself. Patient had her legs wrapped around Security Officer by the time she was on the floor. Patient was on the floor crying. Once Patient was on the floor staff observed the needle Grievant inserted into Patient being removed and the needle was bent at about a 90 degree angle.[13]

11. Neither PNA-1 or PNA-2 observed Patient having her injection site wiped with an alcohol swab before the injection or observed the injection site having a Band Aid or other covering placed after injection. [14]

12. The incident involving Patient occurred on April 8, 2013. The matter was reported on April 30, 2013, in writing, to Facility Director by PNA-1 and PNA-2. By May 1, 2013 an investigator was assigned and Agency began an investigation of matters concerning the incident occurring on April 8, 2013. On May 1, 2013 Grievant was directed not to have contact with Patient until conclusion of the investigation. [15]

13. Upon completion of the investigation an "Investigator Summary" was issued dated May 7, 2013 which, among other matters reported, made the finding, "Based on the preponderance of evidence, there is sufficient evidence to support the allegation of abuse." [16]

14. On May 15, 2013 Grievant was provided a due process letter informed her in writing Facility Director found her interaction with Patient was abusive. Grievant was advised of the intended action of termination and the basis thereof. Agency afforded Grievant 24 hours to present any evidence and respond. Also, Agency offered to meet with Grievant to consider any further mitigating evidence Grievant

[11] A. Tab 4. and testimony.
[12] A. Tab 4 and testimony.
[13] A. Tab 4 and testimony.
[14] A. Tab 4 and testimony.
[15] A. Tab 4, Document 4 and testimony.
[16] A. Tab 4, Investigator Summary.

wished to offer. On May 15, 2013 Grievant responded in writing to the 5/15/13 notification of Agency's intended termination (due process letter).[17]

15. Investigator is a DBHDS trained investigator. Investigator, when assigned, was not involved with the issues under investigation.[18]

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 of Virginia. This comprehensive legislation includes procedures for hiring, promoting, compensating, discharging, and training state employees. It also provides for a grievance procedure. Code of Virginia, §2.2-3000 (A) sets forth the Virginia grievance procedure and provides, in 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 employee disputes which may arise between state agencies and those employees who have access to the procedure under §2.2-3001.

Standards of Conduct and Client Abuse:

Agency's Employee Handbook, September 2009, *Chapter 14: Standards of Conduct and Client Abuse* provides, in pertinent part, as follows:

> …. The Commonwealth of Virginia has a set of rules governing the professional and personal conduct and acceptable standards for work performance of employees or *Standards of Conduct*. The *Standards of Conduct* (DHRM policy 1.60) is promulgated by the Department of Human Resource Management (DHRM) and is applicable to all non-probationary classified employees.
>
> The *Standards of Conduct* was developed to protect the rights of all employees and their well being in the workplace. They are designed to be used to correct unacceptable behavior or performance. ….
>
> The *Standards of Conduct* is intended to be illustrative and not all-inclusive. Accordingly, an act, which, in the judgment of the agency head or his/her designee, although not listed in the policy, seriously undermines the effectiveness of the agency's activities or the employee's performance, is to be treated consistent with the provisions of the *Standards of Conduct*.
>
> **Group III Offenses**
>
> These offenses include acts and behaviors of such a serious nature that a first occurrence normally should warrant suspension of up to 30 workdays or termination.
>
> (13) Violation of the State's or agency's policies on Client Abuse … (may be treated as a Group I, II, or III offense depending on the severity of the conduct)

[17] A. Tab 2 and G. Green Tab.
[18] Testimony.

Client Abuse and Neglect

The Department has a duty to provide a safe and secure environment to the individuals receiving services and to employees. Additionally, the Department has a philosophy of "zero tolerance" for acts of abuse/neglect because the individuals receiving services represent a particularly vulnerable, fragile, often dependent portion of the population. They require treatment and protection, some for up to 24 hours per day, 365 days per year. Many clients are unable to recount, verify or testify to what happened. This is of particular concern when there are allegations of abuse/neglect of individuals receiving services from the Department.

The Department's policy regarding investigation of allegations of abuse/neglect is Departmental Instruction 201 …

"Abuse" means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, 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. …[19]

12 VAC 35 -115-50 Dignity **provides**, in pertinent part:

A. Each individual has a right to receive his legal, civil, and human rights, including constitutional rights, statutory rights, and the rights contained in these regulations, except as specifically limited herein. Each individual has a right to have services that he receives respond to his needs and preferences and be person-centered. Each individual also has the right to be protected, respected, and supported in exercising these rights. Providers shall not partially or totally take away or limit these rights solely because an individual has a mental illness, mental retardation, or substance use disorder and is receiving services for these conditions or has any physical or sensory condition that may pose a barrier to communication or mobility.

B. in receiving all services, each individual has the right to:

2. Be protected from harm including abuse, neglect, and exploitation.

Departmental Instruction 201 [20]

Agency has developed and promulgated Department Instruction 201 (RTS) 03 ("DI 201") – "Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities" which provides, in pertinent part, as follows:

201-1 Background

The [Department] has a duty to provide a safe and secure environment to individuals receiving services and has a philosophy of zero tolerance for abuse and neglect. The Department will, in all instances, investigate and act upon allegations of abuse or neglect. …

201-3 Definitions

Abuse (Code of Virginia §37.2-100)

[19] A. Tab 5.
[20] A. Tab 3.

> This means any act or failure to act by an employee or other person responsible for the care of an individual in a Department facility 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. …. [21]
>
> **201-05 Specific Guidance**
>
> **Substantiating abuse and neglect**
>
> A finding of the abuse or neglect shall be substantiated by a preponderance of the evidence. The standards for substantiating abuse and neglect will be based on preponderance of the evidence gathered during the investigation process. See *"preponderance of the evidence"* in the definition section.

DISCUSSION:

Agency has a duty to provide Patient with a safe and secure environment and has established a policy of zero tolerance for acts of abuse and neglect. In order for Agency to meet its burden of proof it must show an act or failure to act 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.

DI 201 does not define "recklessly". The New Lexicon Webster's Dictionary of the English Language, Encyclopedic Edition defines "reckless" as: "wildly careless, *reckless driving||indifferent to danger, reckless courage".* Webster's New Dictionary defines "reckless" is defined as, "rash; heedless; careless. Black's Law Dictionary (4th ed.) defines of the term reckless as,

> "Not recking; careless, heedless, inattentive; indifferent to consequences. According to circumstances it may mean desperately heedless, wanton or willful, or it may mean only careless, inattentive, or negligent. It furthermore defines the term recklessness as a rashness; heedlessness; wanton conduct. The state of mind accompanying an act, which either pays no regard to its probable or possible injuries consequences, or which though foreseeing such consequences, persist in spite of such knowledge.

Incident:

Grievant was on duty as an RN at Facility on April 8, 2013 at approximately 12:30 A.M./1:00 A.M. when the incident at arose which gave rise to a Facility investigation. Patient was very agitated, yelling in her bedroom, and upsetting her roommate. Grievant was notified of this. Grievant made the decision to give Patient an IM injection of Ativan after being informed of Patient's agitation, yelling in her room, and her lunging at PNA-1 and PNA-2. Patient was escorted by staff from her bedroom to the dayroom. No other patients were in the dayroom. While waiting in the dayroom for Security, PNA-1 and PNA-2 were able to get Patient to sit down, to calm down some, and Patient was described as no longer being aggressive. Patient did stand up at one point and say she could not stand this anymore and wanted to die and go to heaven.

In response to Grievant's call, Security Officer went to Patient's ward to assist with an IM. He met with Grievant in the nursing office. Shortly after Security Officer arrived Grievant exited the nursing station and stated "Ready" or "Are you ready?".

[21] A. Tab 3.

PNA-1 and PNA-2 helped Patient stand up with one staff on each side of Patient. All three started towards the hallway with Security Officer behind PNA-1. Patient took no more than a step or two when Grievant pulled Patient's pants down exposing an injection site and gave her an IM injection of Ativan in Patient's left hip area. Upon Grievant pulling her pants down Patient immediately started to go to the floor.

Grievant did not discuss or announce her plan of when or where in Facility she would give the injection. PNA-1, PNA-2, and Security Officer were unaware and did not expect Patient was going to be given an injection under these circumstances. They were forced, under the circumstances, to have to grab for Patient as she was going down in order to prevent her from hitting the floor and possibly injuring herself. In the process of Patient going to the floor, the needle in her hip was bent at approximately a 90 degree angle. Grievant sat on the floor crying.

Staff, including Grievant, knew or should have known of Patient's long history of being combative and aggressive when given an injection.[22] PNA-1, PNA-2 and the Security Officer each indicated they believed Patient was going to be taken to her room or to the open seclusion room where the injection would be given her. Staff had even made sure a mattress was available in the open seclusion room and the floor was clear in anticipation of the injection being given there.

The evidence does not indicate Patient, PNA-1, PNA-2, or Security Officer were prepared for or expecting the injection to be given to Patient when it was actually given (i.e. with Patient standing in the dayroom while in the process of being escorted by staff). The evidence further indicates that the Patient and the other staff present were not informed by Grievant that the IM injection was going to be given.

There were strong safety and security concerns both for staff and Patient when she received an injection. Patient had a long and well known history of combative behavior when given injections. Giving the injection to the Patient under the conditions discussed above placed her and staff in a potentially unsafe situation needlessly. This was a violation of the duty to provide a safe and secure environment to Patient and recklessly caused or might have caused physical and/or psychological harm or injury to Patient.

The evidence does not indicate that Grievant told Patient that she was going to be receiving an IM injection. Grievant indicated to Investigator that she doesn't remember if she told Patient that she was going to get an IM but as sick as she was it wouldn't make a difference because she wouldn't comprehend it anyway.

Investigation:

Investigator's investigation involved telephone interviews, in-person interviews, and documentation review. He Interviewed Grievant, Security Officer, PNA-1, PNA-2, and unsuccessfully attempted to interview Patient who would not or could not discuss matters. Investigator, as a result of his investigation expressed a number of concerns and findings including:

- Grievant 's failure to communicate with staff about her plan of where and when Patient was going to get the IM and her decision to give Patient an IM while standing acted to place Patient and staff in an unsafe situation. The failure to communicate contributed to the incident occurring wherein the needle was bent in Patient's hip and led to unnecessary pain and anguish for the Patient.

[22] A. Tab 4 and Testimony.

- Patient was never informed she was going to receive an IM injection of Ativan.
- Grievant did not properly assess Patient. Patient had a long history of unsafe actions when being given injections, both unsafe to herself and to those around her.
- Patient and staff were unnecessarily placed in an unsafe or potentially unsafe situation. Patient reacted when Grievant pulled down her pants to give her a shot in the hip while she was standing and in the process of walking. Staff did not anticipate this and were not prepared or organized for this. Staff had to grab at Patient to prevent any injury to her from her falling to or hitting the floor.
- Grievant did not offer Patient the opportunity of a PO (oral) Ativan. Oral medication of Ativan should have been offered first for a number of reasons, including that it was provided for in the MAR, the MAR indicated that the IM of Ativan should be given in the event an offered PO of Ativan was refused, and showing dignity and respect for patients and their rights
- Grievant did not utilize an alcohol swab or wipe the injection site before administering the injection and this could have led to infection.

Investigator concluded in his "Investigator Summary" dated May 7, 2013 that, based upon the preponderance of the evidence, there is sufficient evidence to support the allegation of abuse.

Alcohol Swab:

There is contradicting evidence as to whether an alcohol swab/pad was used to prepare the site for injection. Grievant indicated in testimony that she did have two alcohol pads in hand and never gives an injection without an alcohol preparation to the site. She indicates that she wiped the site with alcohol when pulled the corner of Patients pants down and gave the injection.

PNA-1 indicated that Grievant never prepped the injection site with an alcohol swab. PNA-2 indicated that she had a clear view when Grievant gave the injection and Grievant did not clean the injection site with an alcohol swab. Security Officer indicated that he was not in a position to observe the injection site but Grievant inserted the needle into Patient right after she pulled her pants down so there was not enough time for her to have prepped the injection site with an alcohol swab. He further stated Grievant didn't wipe the site after removing the needle or put on a band-aid. He indicated he never saw Grievant have any alcohol swabs with her.

Grievant:

Grievant indicated that:

- It is not an uncommon practice in the medical field to give a shot to a patient in the standing position.
- The dayroom may not have been the ideal place to give an injection but she has seen it happen numerous times at Facility, especially in emergency situations, and this is where she was during the crisis. The decision she made to give Patient the medication there was not malicious, it just happened to be where patient was at this time.
- It was not intentional, if she forgot to tell Patient she was going to be given an injection.

Security, PNA-1, and PNA-2 were present with Patient due to concerns for Patient safety and the safety of others. Grievant was in control of circumstances surrounding the delivery of the Ativan

injection. However, she failed to communicate critical matters to available staff and created a situation where Patient could have been injured seriously.

Grievant contends that patients may be given injections while standing. She notes that patients have been given injections in the day room this case involves significantly more considerations. However, the totality of the circumstances concerning this one particular patient must be taken into consideration.

Patient had a known long history of acting out when getting injections, Security was called to assist, and two other staff were staying with Patient in the dayroom. The two staff with Grievant got her to sit down and calm down some, it was indicated she wasn't aggressive at that time. Staff assisted Patient to get up and were in the process of walking when the injection was unexpectedly given. Grievant did not tell other staff present that Patient was being given an injection while upright and/or walking or give any warning of giving the injection. Patient, herself, was not told she was getting an injection.

Staff present (except Grievant) believed the Patient was being escorted the open seclusion room or to her room or for the injection. Both of these sites were commonly used in the past for her injections. It was not unanticipated that Patient would act out or become aggressive when given an injection. Security Officer, PNA-1, and PNA-2 had anticipated giving the injection under a more controlled situation, with coordination of efforts and supports. It was not anticipated that Patient would be standing up where she could fall and an injection given without warning or notice.

Grievant contends that it is common for needles given in injections to bend. The facts concerning the circumstances in this situation (discussed above) in which the needle bent to about a 90 degree angle in Patient's hip are of concern. Patient was going to the floor during the injection process and only while she was on the floor was the needle removed. When it was removed it was bent, Patient was on the floor with her legs around Security Officer, and she was crying.

Taking into consideration the totality of the circumstances, Grievant actions in failing to inform other staff and the Patient resulted in a situation which caused or might have caused physical or psychological harm to Patient.

Investigator:

Grievant contentions that Investigator had improperly labeled her after five minutes of the first telephone conference and contends that Investigator was not impartial. These allegations are not found to be supported by sufficient evidence presented in this cause.

Grievant contends that she was not adequately informed of what was being investigated. However, the evidence indicates that Grievant transmitted to investigator a written communication on May 1, 2013 (the first day of the investigation) focusing on and addressing the incident of April 8, 2013 and detailing the facts and circumstances surrounding Grievant's decisions and actions in giving an IM injection to Patient on 4/8/13 in the dayroom. The communication further appears to clearly identify who the patient was.

At the start of the second interview held on May 6, 2013, in response to her question, Investigator further specifically informed Grievant that he was, "… looking at the entire situation and there were questions about her communications with staff and where and how the IM was given".

The evidence indicates that Grievant was sufficiently and timely informed the nature of the allegations being investigated.

Previous:

Grievant indicated that she has had a previous incident on the ward with one PNA who reported the incident at issue. She contends that the PNA became angry with her and the nursing supervisor and this was the basis or motive for bringing matters to the Director's attention.

While there appeared to be a mutual issue between Grievant and one PNA it is noted that the allegations are brought and signed by PNA-1 and by PNA-2. Moreover, there is another witness to events who work for the Security Department. It is noted also that there appears to be a basic consistency in the events related to Investigator and under oath at hearing by PNA-1, PNA-2, and Security Guard. The facts of Grievant giving the IM Ativan to Patient in the dayroom and while standing, the Patient going to the floor when getting the IM and having her pants pulled, and the bent needle are not contested by Grievant.

Ativan:

Two pages of Medication Administration Record ("MAR") notes were admitted into evidence. As Grievant contends, on one page it appears that it is indicated Ativan can be administered orally every six hours as a PRN for aggression or severe agitation and an Ativan IM given as a backup for refusal. On the other page it appears to be indicated that Ativan IM can be given every 6 hours as a PRN for aggression, agitation, ***or*** refusal of P.O. lorazepam.[23]

In considering the above documents, which contained handwritten deletions and additions, it does not appear that there was a clear requirement that offering an oral dosage of Ativan was necessary before being able to utilize an IM of Ativan.

Delay in reporting:

Grievant raised concern and question as to an approximately 22 day delay between when the incident of 4/8/13 occurred and when it was reported in writing to the Director (i.e. on 4/30/13).

The timeline for events in this cause indicates:

4/08/13 incident being investigated occurred;
4/30/13 incident reported in writing to Director;
5/01/13 investigation initiated by agency, Grievant interviewed by investigator by telephone;
5/07/13 Investigator Summary was made reporting findings;
5/15/13 Due Process Letter to Grievant; and
5/17/13 Written Notice issue.

Investigator inquired as to the 22 day delay in reporting. He was told by both PNA-1 and PNA-2 that they were scared/afraid of Grievant and her retaliation and had to think about it. Also it was indicated that PNA-1 told Investigator that the delay between the incident date and the submission of the complaint was due to her being off, and PNA-2 and herself making up their mind to report it. She added that this was very hard for her to do.[24]

Investigator further testified that under *Administrative Issues* in his *Investigator Summary,* he address this and other issues when he noted, "During this investigation, [PNA-1] and [PNA-2] brought up other issues that are in the past, which should have been reported and taken care of promptly. This needs to be addressed."

[23] Tab 4 Document 7, last two pages.
[24] A. Tab 4. page 5.

Director had a duty to investigate and did investigate the report even thought it was 22 days after the event. Upon the evidence presented in this case, including the timeline of events, the 22 day delay in reporting is not found to prohibit the an investigation into matters or prohibit taking disciplinary action and furthermore, does not act as a denial of due process. Director reviewed the investigation of the allegation of patient abuse and determined that physical abuse did in fact occur. He found that Grievant's interaction with Patient was abusive and in accordance with DI 201 and the Standards of Conduct Grievant Issued a Group III Written Notice and terminated.

Definition of abuse:

Grievant contends that incident of 4/8/13 does not meet the definition of abuse. Due to the nature and condition of the individuals Agency provides services for, Agency interprets "abuse" very liberally. Agency's definition of abuse is very broad and encompassing and Agency has established a "zero tolerance" for abuse.

While providing an injection of Ativan may have been necessary, the manner in which it was administered was neither necessary nor was it appropriate given the circumstances. Grievant was responsible for the care of Patient who was being treated for a mental illness in a Department facility. Grievant knew or should have known Patient's history of being resistive, uncooperative, and combative when given medications, especially injections.

There is no evidence that Grievant intended to cause harm, injury, or death to the Patient. However, certain acts coupled with certain actions she failed to perform caused or might have caused a physical or psychological harm or injury to Patient.

Grievant knowingly and intentionally performed the acts of pulling down the Patient's pants and give an injection at the time she chose, with Patient standing, and without staff being warned or prepared to address any problem.

Grievant recklessly failed to perform the acts of properly assessing Patient and addressing Patients safety needs and considerations, taking in to consideration Patient's long history of combativeness, notifying Patient before giving her an injection, notifying staff of when and where Patient would be when she gave the injection.

Patient fell to the floor and staff unexpectedly had to grab at Patient to prevent her from harm or injury hitting the floor. Patient had a bent needle in her hip and ended up on the floor crying.

These acts (performed and/or failed to be performed) caused or might have caused physical or psychological harm, injury to Patient, a person receiving care or treatment for a mental illness at Facility.

Mitigation:

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 the rules established by the Department of Human Resources Management ..." .[25]

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

[25] Va. Code §2.2- 3005.

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."[26]

The Hearing Officer does not find that the agency's discipline exceeds the limits of reasonableness.

CONCLUSION

For the reasons stated above, based upon consideration of all the evidence presented at hearing, Agency has proven, by a preponderance of the evidence, that:

1. Grievant engaged in the behavior described in the Written Notice.
2. The behavior constituted misconduct.
3. The Agency's discipline was consistent with law and policy.
4. There are not mitigating circumstances justifying a reduction or removal of the disciplinary action and Agency's discipline does not exceed the limits of reasonableness.

DECISION

For the reasons stated above, the Agency has proven by a preponderance of the evidence that the disciplinary action of issuing a Group III Written Notice with termination was warranted and appropriate under the circumstances and the Agency's issuance of a Group III Written Notice with termination is ***UPHELD.***

APPEAL RIGHTS

As the *Grievance Procedure Manual (effective date: July 1, 2012)* sets forth in more detail, this hearing decision is subject to administrative and judicial review. Once the administrative review phase has concluded, the hearing decision becomes final and is subject to judicial review.

A. Administrative Review:

A hearing officer's decision is subject to administrative review by both EDR and Director of DHRM based on the request of a party. Requests for review may be initiated by electronic means such as facsimile or e-mail. A copy of all requests for administrative review must be provided to the other party, EDR, and the Hearing Officer.

A party may make more than one type of request for review. All requests for administrative review must be made in writing and ***received by*** the reviewer within 15 calendar days of the date of the original hearing decision. "***Received by***" means delivered to, not merely postmarked or placed in the hands of a delivery service.

1. A challenge that the hearing decision is inconsistent with state or agency policy is made to the DHRM Director. This request must refer to a particular mandate in state or agency policy with which the hearing decision is inconsistent. The director's authority is limited to ordering the hearing officer to revise the decision to conform it to written policy. Requests must be sent to the Director of the

[26] Rules for Conducting Grievance Hearings § VI. B. 2.

Department of Human Resources Management, 101 N. 14th Street, 12th Floor, Richmond, VA 23219 or faxed to (804) 371-7401 or e-mailed.

2. Challenges to the hearing decision for noncompliance with the grievance procedure and/or the Rules for Conducting Grievance Hearings, as well as any request to present newly discovered evidence, are made to EDR. This request must state the specific requirement of the grievance procedure with which the hearing decision is not in compliance. The Office of Employment Dispute Resolution's ("EDR's") authority is limited to ordering the hearing officer to revise the decision so that it complies with the grievance procedure. Requests must be sent to the Office of Employment Dispute Resolution, 101 N. 14th Street, 12th Floor, Richmond, VA 23219, faxed to EDR (EDR's fax number is 804-786-1606), or e-mailed to EDR (EDR's e-mail address is edr@dhrm.virginia.gov).

B. Final Hearing Decisions:

A hearing officer's original decision becomes a **final hearing decision**, with no further possibility of an administrative review, when:

1. The 15 calendar day period for filing requests for administrative review has expired and neither party has filed such a request; or
2. All timely requests for administrative review have been decided and, if Ordered by EDR or DHRM, the hearing officer has issued a revised decision.

C. Judicial Review of Final Hearing Decision:

Once an original hearing decision becomes final, either party may seek review by the circuit court on the ground that the final hearing decision is contradictory to law. A notice of appeal must be filed with the clerk of the circuit court in the jurisdiction in which the grievance arose within 30 calendar days of the final hearing decision.

S/Lorin A. Costanzo

_____

Lorin A. Costanzo, Hearing Officer