KATHY SPURLOCK,

Grievant,

v. DOCKET NO. 97-VA-504

DIVISION OF VETERANS AFFAIRS,

Respondent.

D E C I S I O N

This grievance was submitted by Grievant Kathy Spurlock directly to Level IV, pursuant to W. Va. Code § 29-6A-4(e), on November 14, 1997, after she was dismissed from her employment with Respondent Division of Veterans Affairs ("VA"), on November 13, 1997, for gross misconduct. Grievant sought as relief to be made whole. A Level IV hearing was held on January 6, 1998, and this matter became mature for decision upon receipt of the parties' written argument on February 9, 1998.

Discussion

The burden of proof in disciplinary matters rests with the employer, and the employer must meet that burden by proving the charges against an employee by a preponderance of the evidence. W. Va. Code § 29-6A-6; Ramey v. W. Va. Dept. of Health, Docket No. H-88-005 (Dec. 6, 1988). "The preponderance standard generally requires proof that a reasonable person would accept as sufficient that a contested fact is more likely true than not." Leichliter v. W. Va. Dept. of Health andHuman Resources, Docket No. 92-HHR-486 (May 17, 1993). Where the evidence equally supports both sides, the employer has not met its burden. Id.

The employer must also demonstrate that misconduct which forms the basis for the dismissal of a tenured state employee is of a "substantial nature directly affecting rights and interests of the public." House v. Civil Service Comm'n., 380 S.E.2d 226 (W. Va. 1989). "The judicial standard in West Virginia requires that `dismissal of a civil service employee be for good cause, which means misconduct of a substantial nature directly affecting rights and interests of the public, rather than

upon trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention.' Syl. Pt. 2, Buskirk v. Civil Service Comm'n, 332 S.E.2d 579, 581 (W. Va. 1985); Oakes v. W. Va. Dept. of Finance and Admin., 264 S.E.2d 151 (W. Va. 1980); Guine v. Civil Service Comm'n, 141 S.E.2d 364 (W. Va. 1965)." Scragg v. Bd. of Dir. W. Va. State College, Docket No. 93-BOD-436 (Dec. 30, 1994).

Prior to her dismissal, Grievant was employed at the Veterans Home in Barboursville as a Licensed Practical Nurse ("LPN"). The Veterans Home is a residence care facility which houses approximately 68 disabled veterans, more than 90% of whom are emotionally disturbed or have a substance abuse problem. The Veterans Home provides no medical treatment, but the nurses maintain certain medical records, dispense prescribed medicine to some residents, take blood pressure readings, and give injections.

Grievant's supervisor was Louise McMullen, a Registered Nurse and Director I, Nursing Services, at the Veterans Home. Ms. McMullen directs the nursing department, makes its policies and procedures, carries out Division of Personnel policies and procedures, the Home's policies andprocedures, and federal rules and regulations applicable to the Veterans Home, and nursing licensure laws. Her staff consists of five LPN's, two health service workers, and one other RN.

Grievant's dismissal letter recites that Grievant was dismissed for:

> gross misconduct, that is, your repeated violation of the professional conduct and ethics standards expected of a Licensed Practical Nurse; your repeated efforts to disrupt the effective and efficient operation of the Nursing Department which has resulted in the creation of a highly negative and hostile working environment, and your repeated violation of the operating policies and procedures of the Nursing Department . . .. Your misconduct demonstrates a willful disregard of the standards of behavior your employer has the right to expect from its employees.

The dismissal letter goes on to recite twelve "specific reasons" in support of the charges, which will be addressed separately. After each of the charges is a citation to one of two sections of the West Virginia State Board of Examiners' "Law and Rules" for Licensed Practical Nurses, dated June 1, 1997. Those two sections are 10.2.12.1.5.12 and 10.2.12.1.5.27. (See footnote 1) These sections state two of the many actions or conditions which may result in the Board of Examiners taking disciplinary action against a licensee. No evidence was presented that Grievant was reported to the Board of Examiners. Section 10.2.12.1.5.12 states, "failing to follow established policies and procedures in the practice setting to safeguard patient care." Section 10.2.12.1.5.27 states, "other acts, which in the opinion of the Board, constitute professional misconduct." (Emphasis added.)

To further set the stage for proper consideration of the charges against Grievant, the Administrator of the Veterans Home, Frederick Hubbard, testified that he had been made aware of the inner-battling which had been going on among the nursing staff. He stated that at first the nurses had joined together against Ms. McMullen, but at some point something happened and they hadchosen sides and were fighting among themselves. He stated this concerned him, but he did not know what could be done. Respondent presented testimony that the working environment was better now that Grievant and another employee have been dismissed.

As will become clear, several of the charges involve nothing more than the nurses not being able to get along. Three of those charges resulted from incident reports filed by another LPN at the Veterans Home, Pat Ramey. Ms. Ramey also filed the incident reports which resulted in charges one, eight, ten, and twelve. Two of the incident reports were filed by Ms. Ramey a month or more after the incident was alleged to have occurred.

The specific incidents which formed the basis of the decision to dismiss Grievant follow.

A.

TURNING IN A RESIDENT WITH INTENT TO CAUSE HIM FINANCIAL PROBLEMS.

The dismissal letter recites this incident as:

> On September 16, 1997, you reported to another staff member that you had discovered that Resident M.S., had additional, unreported income and as a result of the fact that you personally did not like Resident M.S., you turned the resident into the Home for failing to report additional financial income. Turning in Resident M.S. in order to cause him financial problems because you did not like him was malicious and professionally unacceptable (ref. 12.1.5.22).

This was brought to the attention of Ms. McMullen by Pat Ramey, on an incident report form. The incident report form notes September 16, 1997, as the date of the occurrence, but was dated November 6, 1997, 3:30 p.m., and was received by Ms. McMullen on November 6, 1997, at 3:30 p.m. (See footnote 2) The incident report filed by Ms. Ramey states:

> 9-16-97 K. Spurlock called Connie Hodapp to report M.S. (See footnote 3) as having $600 more income than reported to fiscal. Kathy asked this to be kept confidential. She stated Susan Preston (See footnote 4) had told her M.S. had the extra income and since she (K. Spurlock) did not like him she was turning him in to fiscal. This same day the resident told me he was paying over $300 per month to live here and had given 30 day notice that he was leaving.

Ms. Ramey did not offer testimony on this matter.

Ms. McMullen stated federal guidelines require that resident records be kept confidential and the

federal government inspects the Veterans Home annually, checking its compliance with this regulation. She stated it is a violation of LPN rules to report confidential information about a patient in the LPN's care, and that the professional code says that no information is to be taken from the care given and used in a manner which would cause the patient to act in a way which would be detrimental to his health. She stated this resident has a severe emotional problem, and Grievant's action caused him to react very violently. She stated if Grievant had information regarding a resident's income which she believed was true, she should have reported it to her, so it could go through the chain of command. She stated she could have taken it to Mr. Hubbard, who could have talked to the resident, and then taken it to the Fiscal Officer.

Grievant stated she had heard this resident had an additional income, and had discussed it with Ms. Ramey when they were working together. She had asked Ms. Ramey if she thought sheshould report it, and she said yes, so she placed a telephone call to Debbie Thacker, and told her about this. Ms. Thacker told her the fiscal person was not there that day, and she would make a note. She stated she thought she had followed the proper procedure, and was not aware of a policy regarding to whom she was to report this information, or if she should report it. She stated this resident has no psychiatric diagnosis. She stated two residents have the same initials, and Ms. McMullen may have confused the two. Grievant was not asked about her intent in reporting M.S.

First, Respondent agrees that Grievant should have reported the information she had been told. Respondent just believes Grievant should have reported this to Ms. McMullen rather than the person she spoke with in the Fiscal Office. (See footnote 5) The undersigned has reviewed the policies placed into evidence by Respondent, and the only references to confidential information involve medical information, not financial information. Assuming that either Ms. McMullen or the undersigned had the authority or ability to interpret the LPN licensing board's rules, the cited rule likewise talks about safeguarding patient care, not financial information.

Second, the only evidence of Grievant's ill intent is found in the incident report. Grievant was not asked about her intent, but did state she had followed Ms. Ramey's advice in reporting M.S. Although Ms. Ramey was called as a witness, she was not asked under oath whether Grievant had expressed ill intent toward M.S. Ms. Ramey's motives are questionable given the number of incident reports submitted regarding Grievant's activities, many of which do not rise to the level of conduct which should be reported on this form, and the amount of time which elapsed between the date of the

incident and Ms. Ramey's report. Further, Grievant was not aware that M.S. had an emotionalproblem, and could not have foreseen that his emotional problem would result in a violent reaction. Respondent failed to prove it was more likely than not that Grievant intended to harm M.S. by reporting information she had become aware of regarding his financial situation to the Fiscal Office. Respondent has likewise failed to prove that Grievant violated her duty to maintain the confidentiality of patient information.

Finally, while the Veterans Home's policy is that a nurse should report problems to her supervisor, this particular problem did not involve Grievant's nursing duties, but her duty as an employee to report knowledge about a resident's finances. This did not fall under Ms. McMullen's supervision over Grievant, and it is understandable that Grievant would report this to the Fiscal Office directly. The undersigned can find nothing which required that Grievant report this information to Ms. McMullen.

B. VANDALIZING STAFF PHOTOGRAPHS.

On October 22 or 23, 1997, photographs of staff members and their pets which were on the bulletin board in the Medicine Room were defaced. Pat Ramey reported this using an incident report form dated October 24, 1997, 3:00 p.m. This is the one of three incident reports filed by Ms. Ramey on October 24, 1997. While Ms. Ramey did not implicate Grievant in this incident report, the other two incident reports named Grievant.

The dismissal letter referred to this as, "an attempt to create interpersonal problems between and among the Nursing Department and a hostile and negative working environment." It went on to characterize this as "highly inappropriate on a personal level" and "totally unprofessional behavior for a Licensed Practical Nurse," and referenced 10.2.12.1.5.22. Ms. McMullen testified that otheremployees were frightened by this malicious act, they felt it showed a very sick person, and it created hostility and tension.

Respondent failed to prove Grievant had any role in the defacing of the photographs. The evidence presented consisted of Ms. McMullen's testimony that she had overheard Grievant comment to a co-worker that she had vandalized the photographs, and the coincidence that Grievant had returned to work on October 23, 1997, after being off work since October 10, 1997, for a medical condition which had required her to be hospitalized. Ms. McMullen related nothing more about the overheard conversation, nor did she relate the exact words Grievant had used. No one saw Grievant

deface the photographs, and several other persons had access to the bulletin board.

Grievant denied having any role in this incident, and denied admitting to the vandalization. She testified that she had indeed cut herself out of one of the pictures placed into evidence, with the permission of the person to whom the photograph belonged, and that picture was not on the bulletin board, but was in a desk drawer. Ms. Ramey also testified this picture was in a desk drawer.

Ms. McMullen's scant testimony cannot support a finding that Grievant's comment was anything more than an off-hand comment taken out of context, and the coincidence of Grievant's return date was nothing more than that. Respondent has not proven it is more likely than not that Grievant defaced the photographs.

C.

FAILURE TO WORK AND IRRITATING CO-WORKERS.

On October 24, 1997, at 8:00 p.m., Pat Ramey submitted another incident report to Ms. McMullen, stating that a month earlier, during the last week of September 1997, Grievant was reading books rather than working, humming so as to be intentionally annoying, and sighed loudly when asked to perform some task. Grievant's alleged actions were characterized as a violation ofthe policies and procedures of the Nursing home and contrary to nursing standards, and 10.2.12.1.5.12 was cited. Ms. McMullen testified she had already disciplined Grievant for this by giving her a verbal warning, and that she had counseled Grievant about this. She testified, however, that she does not usually put anything in writing when she counsels or verbally reprimands an employee, because every time she puts something in writing, "they file a grievance, they do not take it for the content nor the improvement it was meant to be. She immediately threatened me with grievances." Grievant denied that Ms. McMullen had ever talked to her about this, counseled her, or discussed discipline or her job performance with her.

Ms. Ramey testified Grievant sat and read a book for two or three days and was humming loudly and it disturbed her. She felt Grievant was trying to annoy her, but she did not ask Grievant to stop. She said she had asked Grievant to do a blood pressure check, and Grievant had sighed loudly before performing the task. Ms. Ramey stated she had reported this to Gale Harper, Director of Veterans Affairs, and he had suggested she work a different shift. She did not indicate why she had gone over Ms. McMullen's head to Mr. Harper. Mr. Harper did not recall talking to Ms. Ramey about this matter. Ms. Ramey also did not indicate why she had waited a month to file the incident report,

and had happened to file it the day after the photographs, which included some photos of her, were defaced.

Grievant testified she was not aware of this accusation until the morning she was fired. She testified if there are two nurses on duty, one does medications and the other does paperwork and answers the telephone. Ms. McMullen agreed that the LPN's divide the work in this manner. Grievant recalled reading a medical dictionary while sitting by the telephone. She stated two radios play in the nurse's station continuously, and she may have been humming along with the radio. Shestated she was not deliberately trying to annoy Ms. Ramey, and Ms. Ramey did not mention her humming was annoying her.

Grievant would not be the first employee to sit and read a book when there is work to be done, and each of us has our own little annoying habits. If an employee is not doing any work when there is work to be done, and is annoying others with her humming, it is the supervisor's role to tell the employee to get busy and to stop humming. This is a performance and attitude issue, which may be addressed in the performance evaluation process. Without prior intervention, it does not constitute gross misconduct or good cause for dismissal.

Further, the undersigned concludes that Respondent did not prove the allegation. Ms. Ramey's report frankly lacks credibility. The delayed reporting of this matter to her supervisor indicates to the undersigned that Grievant's conduct was not so far out of line. Grievant's explanation that she was reading a medical dictionary while she was responsible for answering the telephone does not conflict with Ms. Ramey's testimony. The undersigned is also inclined to believe that Ms. Ramey reported this incident to get back at Grievant because she thought Grievant had marked through her photograph. Had Ms. Ramey offered some explanation as to why Grievant might be trying to annoy her, or had she asked Grievant to stop humming and Grievant had continued to hum, or started whistling or cracking gum in place of humming, Ms. Ramey's conclusion as to Grievant's intention might be entitled to some weight.

D.

RUDE AND UNPROFESSIONAL CONDUCT TOWARD A COWORKER.

The dismissal letter recites:

> On October 24, 1997, you were rude and unprofessional. According to a coworker, when another LPN, who was relatively new to the facility, came on duty, you gave her

> a note instructing her to perform a specific duty. [B]eing uncertain as to how tocarry out the assignment, she reportedly asked you for clarification. According to one coworker, you did not assist her, you only replied, "what's the matter, haven't you been oriented?" Your negative response to a coworker's request for assistance was highly inappropriate and further demonstrates your unwillingness to work, it also demonstrates your efforts to create interpersonal problems and a hostile working environment for your fellow employees. Such behavior is contrary to what one would normally expect to occur in any workplace and, once again, violates standards of nursing care (Ref. 12.1.5.12).

This incident was also reported by Pat Ramey on October 24, 1997, at 5:30 p.m., using an incident report form. The incident report states, however, that Susan Preston had handed the new LPN, Kathy Charlton, the note. Ms. McMullen admitted this and testified Grievant was not accused of handing the note to Ms. Charlton, but of making a remark without assisting the nurse. Ms. Ramey had no first hand knowledge of this incident, but rather, had been told what had occurred by Kathy Charlton. Ms. Charlton did not file an incident report on this, and did not testify regarding this allegation.

Ms. McMullen stated at shift change, the person coming on duty counts the medication with the person leaving. Grievant admitted she had made the quoted comment while counting medicine with Ms. Charlton, but said she meant it in a joking way. She stated she did not mean to create a hostile work environment.

Respondent failed to prove this comment demonstrates an unwillingness to work, or an effort to create interpersonal problems and a hostile working environment. There is no evidence that Grievant failed to assist Ms. Charlton after making the comment, or that she was supposed to do so. Grievant was in fact doing her work, by counting medicine with Ms. Charlton. The hostile working environment allegation will be further addressed in the next charge.

E.

CREATION OF A HOSTILE WORK ENVIRONMENT. The dismissal letter recites:

> On October 24, 1997, you questioned a contract LPN, who was relatively new to the Home, about how she felt having worked two shifts without another LPN or RN present. After she told you that she felt a little lost at first, you told her that she should be ready because she would probably have to testify to that. The contract LPN in question told Mrs. McMullen, R.N., about the incident and reported that she didn't feel like she could work at the Home anymore due to the stress and tension. Your attempt to create a hostile working environment for the contract LPN was highly improper, totally unprofessional and contrary to nursing standards (Ref. 12.1.5.22).

The contract LPN was Ms. Charlton. Ms. Charlton committed this incident to writing on October 24, 1997, and her written statement is essentially the same as what is written in the dismissal letter.

She testified she felt like she was constantly being watched, not just by Grievant, but by all the nurses, and that they were all watching each other, and were reporting on each other to Ms. McMullen. Obviously, she did not mean by her comment in her written statement that Grievant was totally to blame for the stress and tension on the unit. Ms. Charlton's comment that nurses other than Grievant were always running to Ms. McMullen to tell on each other is borne out by the evidence in this grievance.

Grievant stated she and Ms. Charlton were counting medications at shift change, and she recalled asking her how she felt about working alone, but did not recall commenting to her that she might have to testify about it.

Respondent failed to prove that Grievant had created a hostile working environment, or that this comment alone or in combination with the one addressed in the previous section, was an attempt to do so. If there was a hostile working environment, it was the result of a group effort by all the nurses. Further, Ms. McMullen's reference to the very broad provision of the Board of Examiners' rules for LPNs to support that this comment is contrary to nursing standards, is misplaced. Thereferenced provision allows the Board of Examiners, not Ms. McMullen, to determine what acts constitute professional misconduct. Ms. McMullen cited no opinion of the Board of Examiners that such an action constituted professional misconduct.

F.

FAILURE TO DOCUMENT RETURN OF MEDICATION BY RESIDENT AND ERRORS IN RECORDING PASS INFORMATION.

The dismissal letter relates this charge as follows:

> On October 25, 1997, it was reported to Mrs. McMullen, R.N., by one of your coworkers that you had failed to properly document that Resident D.B., had returned medication to you upon his return from a pass. You admitted to Mrs. McMullen, R.N., when questioned about this matter by her on October 25, that Resident D.B., had, in fact, returned the medication. On that same day you incorrectly recorded that Resident G.P. had gone on pass, when, in fact, it was that resident's brother, L.P., who had left on a pass. This error caused unnecessary trouble for Resident G.P., and the nurse who refused to give him the medicine that he justly had coming to him. Further, a more disturbing thing was noted. Upon checking the records, Mrs. McMullen, R.N., discovered that when you logged Residents G.P. and L.C., "out" on pass on October 25, 1997, you indicated in the log book that they would not return until June 27 and February 27, respectively. It is difficult to imagine why you would record the two "passes" as being eight and four months in length, respectively. Errors such as these violate Nursing Department policy and procedures and nursing practice standards (Ref. 12.1.5.12).

Ms. McMullen explained that the Veterans Home logs in prescription medication the residents

receive, and holds and dispenses it as needed to some of the residents. Some residents are self-medicating. She stated residents may leave the Veterans Home, but the Home keeps track of who has left and the time of departure, by recording this information in the log book, and the resident's chart. The residents leave on a "pass," and the departure time is noted by the nurses, as well as by the security guard. When a resident leaves, he is responsible for coming to the unit and picking up his medication. The nurses dispense to the resident all the medicine he will need while he is gone. The nurses record on the medication administration sheet, referred to as the "MAR", andon the resident's chart, that they have dispensed the medication. Importantly, she stated the nurses usually, but not always, record how many days the resident will be gone. The Veterans Home must keep accurate records of what has happened to the prescription medication held for the residents.

On October 25, 1997, Resident D.B. returned medication to Grievant, and Grievant did not record this. Ms. McMullen stated it is standard nursing procedure, the policy of the Veterans Home, and Pharmacy Code, that when medication is returned the nurse is to record the name of the resident, the amount and type of medication returned, and when it was returned.

Betty McNealy, an LPN at the Veteran's Home, testified D.B. came to the nurses's station for his medication, and told her he had returned his two pills to Grievant. She could find no documentation of this, so she took his word for it and gave him his medication. She stated the MAR should have been marked that medication was returned, so that when she dispensed the medication she could have marked that it was given again. She was not aware of a written policy requiring this, or setting out how to report returned medication.

Grievant stated when the resident brought the two pills to her they were not in a bag or container, and he told her he had returned early. She stated she returned him from pass, and put the two pills in the medicine bottle. She stated this was the practice which had been used before, and she was not aware of a policy on documenting return of medication. She said she had put in the report that the resident had returned, but may have omitted stating he had returned the pills.

Respondent has proven Grievant did not record that she had received medication from D.B. when he returned early from his pass. While the Veterans Home may not have had a written policy regarding where to record that medication had been returned, it is obvious that this should have been recorded somewhere. Given the Veterans Home's practice of keeping track of medication, as willbe addressed in the remaining charges, such as counting medication when it is received from the

pharmacy and recording the pill count, recording when medication is dispensed, and Grievant's own recording of medication dispensed to someone who had already received his medication as addressed in charge H, the undersigned finds it incredible that Grievant did not know she should record when medication is returned. Regardless of whether Grievant had been trained to do this, common sense would indicate as much. If there was no policy on where to record the information, Grievant could have asked her supervisor what to do; or if she was not available, she could have filed an incident report or listed it in the nurse's notes, so that at least there would be some record that this medication was back in the hands of the staff.

That same day, Grievant recorded that G.P. had left on a pass, when in fact it was L.P. who had left. Ms. McMullen stated that the problem was when G.P. came to the nurse's station for his medication, the LPN on duty told him he was supposed to be on pass, "so you've already gotten your medicine." Ms. McMullen did not testify that the resident's chart or the MAR showed that medication had been dispensed for G.P. for the period he would be on pass.

Ms. McNealy testified that Grievant had written in the report that G.P. had gone without his medicine. She stated they are not allowed to give medication to anyone on pass, and she had asked G.P. if he had signed back in, and he then told her he had not been on pass. She explained this had caused a conflict between her and the resident. She stated the security guard also keeps a record of who is out on pass.

Grievant stated the guard had told her it was G.P. who had left, and that is what she had recorded. While it is possible Grievant was in error, it is also possible that the security guard was the one who was confused about the names, and told Grievant the wrong person was leaving. Respondent failed to prove it was more likely than not Grievant was in error.

Also that day, Grievant had written in the log book that G.P. would return on June 27, and L.C. had left on a pass and would return on February 27. Ms. McMullen stated she was concerned about Grievant's confusion about dates, and would be concerned about whether she was properly reading medication orders, and dispensing medication properly, and documenting in client's charts properly. She stated Grievant had written down return dates for these residents which were not in the realm of possibilities, as the residents can only receive so many days of furlough.

As noted above, Grievant was not required to record when the residents would return. While this type of error is cause for concern, the fact that she recorded the incorrect return date was not a

violation of any policy or procedure.

G. FAILURE TO GRAPH BLOOD PRESSURE.

The dismissal letter relates that on October 29, 1997, Grievant failed to graph resident D.G.'s blood pressure when she took it, and failed to document it in the nurse's notes, in violation of Nursing Department procedures and practice standards, citing 10.2.12.1.5.12. This incident was reported by Pat Ramey at 4:30 on October 29, 1997, and was signed by Ms. McMullen as received on October 30, 1997, at 7:15. Ms. Ramey noted on the incident report that D.G. "has a clinic app't 10/30/97 for B/P check. I pulled flow sheet to place with progress notes and B/P had not be[en] grafted. I checked nurses notes and no notes made."

Ms. McMullen testified she had graphed D.G.'s blood pressure after receiving a telephone call from D.G.'s doctor, and the doctor had "chewed her out" about the blood pressure not beinggraphed. Ms. McMullen stated that D.G.'s blood pressure had not been taken as often as it was supposed to be taken, but she did not blame this on Grievant. Respondent placed into evidence the "24 Hour Nurses Report" for October 29, 1997, which notes that D.G.'s blood pressure was taken during the first shift that day, and was 170/104. Kathy Spurlock had signed the report as the on-duty LPN that shift.

Ms. McMullen stated nurses were instructed to put any unusual occurrences on the 24 hour report, to put anything they did on the resident's chart, and to report anything which needed attention to her. She stated that failure to properly maintain records could result in a resident not receiving the proper medication. She stated if "it has been asked for" and a resident is on blood pressure medication, it is standard procedure to graph the resident's blood pressure. She stated she would expect the nurse who took the resident's blood pressure to chart the results, rather than the other on duty nurse. She stated a doctor had ordered this resident's blood pressure to be checked daily.

Grievant testified she was not aware of any policy regarding where a blood pressure reading is to be recorded. She stated a lot of residents ask to have their blood pressure checked, and sometimes it is not recorded anywhere.

This charge is the most difficult to evaluate. Ultimately, the undersigned concludes that Respondent failed to prove Grievant knew she was to graph D.G.'s blood pressure. The testimony received regarding procedures showed that the only way Grievant would know this was to be done

was if the doctor's orders were placed on the proper documents. Respondent introduced no evidence that this had been done. Respondent likewise failed to prove that Grievant had received instruction that a resident's blood pressure reading was to be recorded in the nurse's notes, rather than on the 24- hour report.

H. IMPROPERLY DISPENSING MEDICATION AND ALTERATION OF MEDICAL RECORDS.

The dismissal letter states that on October 31, 1997, Grievant improperly gave resident D.S. medication when she was aware he already had his medication in his possession, as it had been given to him when he picked up his medication to leave on a pass, and this had been recorded. When Grievant dispensed D.S.'s medication, she recorded this on the medication record by adding a second column for October 31, 1997, so that the record correctly reflected that she had dispensed medication. Respondent called this recording of information an alteration of medical records, which "compromised the integrity of the particular medical record in question. Such blatant and willful disregard for proper medication administration and documentation procedures is clearly unsatisfactory job performance and in violation of nursing standards (Ref. 12.1.5.12)."

Grievant filed an incident report, after Ms. McMullen told her to do so, on October 31, 1997, at 9:05 a.m., as follows:

> D.S. to N/S [Nurse's Station] for AM meds. Meds given. Immediately I went to sign MAR and "PASS" had been written on the MAR for Oct 31. No where for me to sign. Resident paged to nursing. He said that he was given meds last night but he did not take pass med this AM, that he only took what I gave him. Med cards still in slot for 9AM.

Ms. McMullen stated the LPN's had been told on numerous occasions that if the records show a resident is on pass and has received his medication, and the resident shows up for his medication, the resident is to return the medication which had been dispensed for the period he would be on pass, the medication is to be logged back in, and then the resident is given only the medication to be dispensed at that time; or the resident is to be told to take the medication he was given. She stated the morning report would have listed who was on pass, the MAR would haveshown the resident was on pass, and the chart showed the resident's medication had been given to him.

Ms. McMullen stated that by Grievant writing in a second October 31, she had altered a medical document, which makes it appear there were two October 31sts. Ms. McMullen admitted that if

medicine is given to a resident, it must be recorded. Obviously, Grievant was in a Catch 22. If she did not record she had dispensed medication she would be in trouble, and by recording on the proper form that she had dispensed medication, she was in trouble.

Grievant testified that every resident has a medicine card for each of his medications, and for the six years she worked at the Veterans Home, they have set up medicine from those cards, not from the MAR. She stated that was the way she was taught to set up medicines at that facility, and Ms. McMullen was aware of this. She was not aware of any policy which explained how medicines were to be set up at the institution, and believed the procedure used varied from one institution to another. She stated when two people are working, the person on medicines goes immediately into the medicine room and starts setting up medicine. She stated D.S.'s medicine card should have been removed from the slot, because he was supposed to be out on pass, but the card had not been removed. Ms. McNealy confirmed that when a resident goes out on pass and is dispensed his medication, his card is pulled, or if it is a short pass, they turn the card around so the next nurse knows the medication has already been given, or the card is put in a different section.

Grievant stated she had set up D.S.'s medicine from the card, he had come and gotten it, and when she went to document it, she saw he had already received his medication. However, she had to document that she had given him his medication, so she did so by writing it on the MAR, creating a second column for October 31. She stated when she discovered he had already received hismedication, she immediately paged him. He responded to the page, and told her he had not taken his pass medicine, because he was saving it for his pass.

Ms. McMullen stated the medicine cards should always be compared to the MAR at every shift, and this is taught in the LPN training. She stated she has found errors on the medicine cards, and that is one reason to check the other document. Only after she was recalled as a rebuttal witness, and was being cross-examined, did she reveal that the nursing staff as a whole was doing exactly what Grievant had done. She testified she was not aware of the practice of relying solely on the cards until she did an audit about a month before the hearing and discovered the nurses were relying solely on the medicine cards in preparing medicines. She stated they were about to undergo a change because the nurses were not following the proper procedure, and the nursing manual for the institution would be changed to reflect the proper procedure.

Grievant proved she was following the accepted practice of the Veterans Home in dispensing

medication from the medicine cards, and in recording on the MAR that medication had been dispensed. In regard to this charge, Respondent failed to prove Grievant committed any error for which she can be disciplined.

I.

FAILURE TO PROPERLY LOG IN MEDICATION.

This allegation resulted from an incident report filed at 4:30 p.m., on November 4, 1997, by Pat Ramey. It states, "11/4/97 2 30 K Spurlock brought mailed meds from Administration for [name omitted on exhibit] and just laid on counter. Did not log in book received." Respondent's Exhibit 20. The failure to log in medication was cited as a violation of departmental procedures and nursing standards, and 10.2.12.1.5.12 was again referenced. Ms. McMullen stated the proper procedure when medication is received is to log in the date and the name of the person receiving the medication, to count the medication and report the count on the label, to record in the resident's medication sheet that the medication was received, the date, time, number of pills, and the number of refills. She stated this helps them keep track of who needs medication. She stated medication left laying on the counter can be lost or put away without proper documentation, tampered with, or given to the resident without any documentation. She then admitted that nurses cannot open the medication unless the resident is present. She stated if a resident is called to the nurse's station and he does not show up, or if the resident is not on site when medicine comes in, the medicine is to be placed in a wire basket.

Ms. Ramey, however, stated the medicine has to be logged into a book as received, whether the resident comes down so the medication can be opened or not, and she had logged in the medication. Grievant stated the only sign-in sheet she was aware of for recording delivery of medicine was titled "locked box medicines," and it does not say anything about medicine delivered by the mail carrier. She stated the medicine lays on the counter until the resident comes down so it can be opened. Grievant could not further address what she had done in this instance, as her termination letter did not provide any information on who the resident was, nor did the incident report, or the testimony.

The undersigned concludes from the conflicting testimony of the three witnesses that there was no clear policy on what to do with medication received while waiting on the resident to respond to a page so the package can be opened. Respondent failed to prove Grievant violated any policy.

J.

FAILURE TO ENTER RESIDENT'S MEDICAL APPOINTMENT ON

> **THE SCHEDULE BOOK.** Jessica Porter filed an incident report on November 6, 1997 at 1:00 p.m., stating she had put C.M.'s appointments in the schedule book. "They had been left on the desk by K. Spurlock LPN." This was cited as a violation of "Nursing Department procedures and nursing standards (Ref. 12.1.5.12)."

Ms. McMullen stated residents are to bring their appointment cards to the nurses, and the nurses record appointments in the appointment book so the residents do not miss them. She stated the nurse normally records the appointment as soon as the card is brought to her, and then returns the card to the resident. Otherwise the resident will come back and get the card later. She admitted it was possible that the other on-duty nurse was responsible for recording appointments on November 6, 1997, if Grievant was doing medications. Ms. McMullen stated she remembered Ms. Porter being upset by the way Grievant had thrown the card down. Ms. Porter, however, testified she had found the appointment card laying on the desk and had recorded the appointment in the schedule book. She did not explain why she had referred to Grievant in the incident report.

Grievant could not recall whether she was doing medicines or reports that day, and if she were doing medicines, she would not have been responsible for recording appointments. She stated if one nurse misses putting an appointment in the book, it is the next nurse's responsibility to record the appointment.

Respondent failed to prove Grievant was responsible for recording the appointment.

K.
POSSESSION OF CONFIDENTIAL INFORMATION.

The dismissal letter states:

> On November 7, 1997, one of your coworkers reported that she had observed on November 6, 1997, copies of internal Nursing Department documents protruding from a folder in your mail slot in the Nursing Department. When Mrs. McMulleninvestigated she found a copy of the 24-hour log for October 18, 1997, and copies of the Nursing Department's appointment calendar for the period October 20-24, 1997. You had no authorization or legitimate reason to possess such confidential information and were clearly in violation of Nursing Department procedures and the standards of nursing practice (Ref. 12.1.5.12).

Pat Ramey had reported the papers protruding from Grievant's mail slot. The incident report she filed on November 7, 1997, at noon, states:

> 11/6/97 6 15/p Found folder in employees mailbox (nurses station) with Kathy Spurlock's name on it. Inside this folder contained K. Spurlock's time sheet with copies of time sheets and leave slips. Also contained in folder was copies of internal documents which included 24 hr sheet, appointment schedules for October 20-24th, 1997 plus an incident report on C.B. - 2. DON notified.

Ms. McMullen testified she had removed the folder from the mail slot and found the documents.

Respondent failed to prove this charge. The evidence consisted of the testimony of Ms. McMullen that she had seen Grievant put a folder into her own mail slot, and of Ms. Ramey that she had seen documents sticking out of an envelope in Grievant's mail slot. The mail slot did not have Grievant's name on it, as Grievant had previously removed her name from it. It was not in a locked area, and persons other than Grievant had access to it. While Ms. McMullen was certain the file folder found to contain the documents was the same one she had seen Grievant place in the mail slot, she did not see what was in the file folder at the time Grievant placed it in the mail slot, and admitted someone else could have placed the documents in the folder after it was placed in the mail slot. Ms. Ramey testified she thought it was strange to see anything in Grievant's mail slot, because Grievant had been locking everything up for months. Grievant denied that any of the documents identified was in her possession. She could not recall whether she had placed a folder in this box. It is more likely than not that had Grievant ever had these documents in her possession she would never haveplaced them in a mail slot where any of the staff could see them, but would have put them in her locker.

Summary

Respondent proved one of the many charges against Grievant. In some cases where only a few of the charges have been proven, the Grievance Board has directed the agency to determine whether the same discipline should be imposed. The undersigned declines to take this course in this case. It is clear to the undersigned that Ms. McMullen had decided to get rid of Grievant one way or the other, and it would serve no useful purpose to ask the agency to reevaluate whether Grievant should be dismissed for the proven charge. Further, the dismissal letter itself recites, "[w]hile no single example of inappropriate, counterproductive or unprofessional conduct would, by itself, warrant dismissal, the cumulative effect of your conduct and behavior is one of overall unsatisfactory and unacceptable performance."

The undersigned may mitigate the discipline imposed only if the penalty assessed is so clearly excessive or clearly disproportionate to the offense that it indicates an abuse of discretion. "Considerable deference is afforded the employer's assessment of the seriousness of the employee's conduct and the prospects for rehabilitation." Olah v. W. Va. Dept. of Health and Human Resources, Docket No. 96-HHR-055 (May 19, 1997). Factors to be considered in this analysis include the

employee's past disciplinary record, the clarity of notice to the employee of the rule violated, and whether the employee was warned about the conduct, and mitigating circumstances. Stewart v. W. Va. Alcohol Beverage Control Comm'n, Docket No. 91-ABCC-137 (Sept. 19, 1991). "[T]he work record of a long time civil service employee is a factor to be considered in determining whether discharge is an appropriate disciplinary measure in cases of misconduct." Buskirk, supra. "`Progressive and corrective discipline is not simply an escalator to crucify an employee. Through it an employer must demonstrate an honest and serious effort to salvage rather than savage an employee. To hold otherwise distorts, demeans and defeats the goals underlying the concept of progressive and corrective discipline.' Philanthropic Mutual Life Ins. Co. and Food and Commercial Workers Union, Local 1776, 91-1 ARB ¶ 3210 (May 11, 1990)." Altizer v. Dept. of Health and Human Resources, Docket No. 94-HHR-1089 (Apr. 13, 1995). The record does not reflect that Grievant had been disciplined before.

The record does not reflect what Grievant's past performance record was, or that Respondent considered her past performance in evaluating the proper discipline to be imposed. The only evidence of Grievant's past performance is testimony from Ms. McMullen and Ms. Ramey that Grievant's performance began to decline in September 1997, and that prior to that time Grievant had always kept busy.

Grievant's failure to record the receipt of medication from a resident for which the Veterans Home was responsible is a serious matter. The Veterans Home obviously must take good care in keeping track of the prescription medications for which it is responsible. Grievant obviously did not understand the importance of this.

It is also clear the Ms. McMullen took no responsibility for seeing that her nurses were following proper procedures. She repeatedly stated they had been taught the proper procedures in nursing school. Ms. McMullen cannot simply close her eyes to what her nurses are doing by reciting the mantra they should have been trained to do it right, and then blame the nurses when the procedures they have been following are incorrect or incomplete. The undersigned concludes that Grievant's failure to record medication she received did not, in fact, compromise the health or safety of any patient, and that this single act does not justify her dismissal in light of the evidence in this case. Some discipline, however, is appropriate because this is a serious matter, and Grievant did not seem to understand the importance of recording this information. Grievant's dismissal should be reduced to

a suspension without pay, not to exceed fifteen days. The undersigned will leave it to Respondent to determine the appropriate length of the suspension within that parameter.

The following Findings of Fact are made based upon the record developed at Level IV.

Findings of Fact

1. Grievant was employed by the VA as a LPN at the Veterans Home at Barboursville for a little over six years preceding her dismissal on November 12, 1997.

2. The Veterans Home is a residence care facility which houses approximately 68 disabled veterans, more than 90% of whom are emotionally disturbed or have a substance abuse problem. The Veterans Home provides no medical treatment, but the nurses maintain certain medical records, dispense prescribed medicine to some residents, take blood pressure readings, and give injections.

3. On September 16, 1997, Grievant reported to the Fiscal Office that resident M.S. had additional income he had not reported. This did not violate any policy.

4. Grievant did not vandalize any photographs.

5. During the last week of September 1997, Grievant read a medical dictionary while she was responsible for answering the telephone. She did not hum with the intention of annoying Pat Ramey. 6. Grievant did not create a hostile working environment.

7. On October 25, 1997, the security guard called and told Grievant G.P. had left on a pass, and that is what she had recorded.

8. On October 25, 1997, Resident D.B. returned medication to Grievant, and Grievant did not record this. The Veterans Home is required to keep a record of all medication received and dispensed. It is standard nursing procedure that when medication is returned the nurse is to record the name of the resident, the amount and type of medication returned, and when it was returned.

9. Grievant was not required to record when residents would return. While this type of error is cause for concern, the fact that she recorded the incorrect return date was not a violation of any policy or procedure.

10. On October 29, 1997, Grievant took resident D.G.'s blood pressure, and recorded the reading in the 24 hour nurse's report. She did not graph the reading or record it in the nurse's notes. Grievant did not know the doctor's orders were to graph the blood pressure and that the reading should be recorded in the nurse's notes, rather than the 24-hour report.

11. Every resident has a medicine card for each of his medications, and for the six years Grievant worked at the Veterans Home, the nurses have set up medicine from those cards, not from the MAR. That was the way Grievant was taught to set up medicines at that facility, and she believed this was the policy at the facility.

12. On October 31, 1997, D.S.'s medicine card should have been removed from the slot, because he was supposed to be out on pass, but the card had not been removed.

13. On November 4, 1997, Grievant left a resident's package of medication, received in the mail, on the counter at the nursing station. There was no clear policy on what to do withmedication received while waiting on the resident to respond to a page so the package could be opened.

14. Grievant was not responsible for recording C.M.'s appointment in the schedule book on November 6, 1997.

15. Grievant did not possess copies of confidential internal nursing department documents found in a mail slot on November 6, 1997.

The following Conclusions of Law support the Decision reached.

Conclusions of Law

1. Pursuant to W. Va. Code § 29-6A-6, the burden of proof in disciplinary matters rests with the employer, and the employer must meet that burden by proving the charges against an employee by a preponderance of the evidence. Ramey v. W. Va. Dept. of Health, Docket No. H-88- 005 (Dec. 6, 1988).

2. Respondent has proven Grievant failed to record that she had received medication from a patient, that this information should have been recorded, and that this was a serious violation of procedure.

3. Respondent failed to prove any of the other charges against Grievant.

4. Grievant proved dismissal was too severe a penalty for the violation proven.

Accordingly, this grievance is **GRANTED IN PART, AND DENIED IN PART**. Grievant's dismissal is reduced to a suspension without pay, not to exceed fifteen days. Respondent is **ORDERED** to pay Grievant all back pay to which she is entitled, as though she had not been dismissed, plus interest.

Any party may appeal this decision to the circuit court of the county in which the grievance occurred and such appeal must be filed within thirty (30) days of receipt of this decision. W. Va. Code

§29-6A-7. Neither the West Virginia Education and State Employees Grievance Board nor any of its Administrative Law Judges is a party to such appeal and should not be so named. Any appealing party must advise this office of the intent to appeal and provide the civil action number so that the record can be prepared and transmitted to the appropriate court.

BRENDA L. GOULD

Administrative Law Judge

Dated: February 27, 1998

Footnote: 1

The dismissal letter erroneously cites this provision as 10.2.12.1.5.22, as Ms. McMullen was looking at an older version of the "Laws and Rules" when she assisted in drafting the dismissal letter.

Footnote: 2

The incident report form states it "is to be used for incident (Example: fire, incorrect administration of medicine, theft, abuse, violation of rules by residents or employees, etc.) Any accident or injury involving visitors, residents, vendors, volunteers, etc." The Veterans Home's Nursing Policy at Article V states that incident reports are to document "exceptional or noteworthyoccurance [sic] or events relating to the health, safety, welfare and or medical treatment of a resident, employees or visitor," and specifically, "any medication error of any kind."

Footnote: 3

The parties requested that the names of residents be omitted from the record, and initials be used instead. This request was granted as reasonable, and is consistent with the Grievance Board's practice.

Footnote: 4

Ms. Preston was also an LPN, and was dismissed. Her dismissal is the subject of a pending grievance at Level IV.

Footnote: 5

Neither the dismissal letter nor Respondent's post-hearing written argument note any problem with Grievant discussing this matter with Ms. Ramey. Accordingly, the undersigned will not consider whether this was appropriate.