PATRICIA OLAH,

Grievant,

v.

DOCKET NO. 96-HHR-055

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES/SUBSTANCE ABUSE UNIT,

Respondent.

D E C I S I O N

Grievant, Patricia Olah, filed this grievance on February 7, 1996, protesting her dismissal from West Virginia Department of Health and Human Resources/Huntington Substance Abuse Unit on February 1, 1996. Grievant also alleges harassment and disparate treatment, and seeks to be reinstated with all back pay and benefits. (See footnote 1) Hearing was held on June 24, 1996, October 16, 1996, and February 14, 1997, and this casebecame mature on March 14, 1997, the deadline for the parties' submission of proposed findings of fact and conclusions of law. Grievant did not make post-hearing submissions.

Discussion

The Huntington Substance Abuse Unit ("HSAU") is a residential treatment program for alcohol and drug addictions. Grievant was employed by HSAU as a Licensed Practical Nurse II ("LPN II") for ten years, until her termination for gross misconduct on February 1, 1996. R. Ex. 13. Grievant's immediate supervisor, Robert Nida, Nursing Director, HSAU, was approached at approximately 3:00 p.m. on January 24, 1996, by a patient, Mr. C., who presented him with withdrawal symptoms, and indicated that he had not received his 2:00 p.m. medications. Grievant was the LPN in charge of medications during the day shift (7- 3:00 p.m.) on January 24, 1996. Mr. Nida took Mr. C.'s vital

signs. His heart rate and blood pressure were inflated, and he was very flushed, sweaty, and tremorous, all symptoms of alcohol withdrawal. R. Ex. 5. Mr. Nida assessed Mr. C. as being very near his seizure threshold. Mr. Nida took care of Mr. C. at that time, including ordering his medication, and the next day, January 25, 1996, proceeded to investigate the matter further. Mr. Nida was informed by the evening shift nurses, the patients, and the records, that eight patients, including Mr. C., had not received their 2:00 p.m. medications on January 24, 1996.

The Medication Administration Records for eight patients (R. Ex. 2) indicate those patients were scheduled to receive 2:00 p.m. doses of Ativan, a controlled drug, as part of their treatment for addictions. Those records indicate on January 24, 1996, no medications were charted as given at 2:00 p.m., except for patients G.F. and C.D. LPNTina McComas gave those two patients their 2:00 p.m. medication upon arriving on the evening shift on January 24, 1996, after learning they had not received their medication. The HSAU is required by Federal law to count controlled drugs at the beginning and end of each shift, and every time a patient receives a controlled substance, it must be recorded. HSAU's Controlled Drug Administration Records for the drug, Ativan, do not indicate the drug was administered to the patients at 2:00 p.m. on January 24, 1996, again, with the exception of G.F. and C.D., with the notation that LPN McComas administered the medication. Also excepted is patient B.J., who apparently was discharged that day, and received his 2:00 p.m. medication from Grievant before his discharge. R. Ex. 1.

Mr. Nida spoke to several individuals regarding this incident. Substance Abuse Counselors Lana Gerlach and April Rayburn were present with Grievant on the afternoon of January 24, 1996, in the medical records room, when patient Mr. C. approached her, looking flushed and sweaty. They provided Mr. Nida with written statements, indicating Grievant told Mr. C. to go lay down and she would check on him in ½ hour. Grievant did not take any vital signs or otherwise examine Mr. C. They both indicated Grievant had been talking with them about some personal business, and that after Mr. C. left, she resumed talking about her business. R. Exs. 3, 4. Mr. C.'s Vital Signs Sheet and Progress Notes confirm Grievant did not take Mr. C.'s vital signs; however, she did make a notation that he had complained of not feeling well, and that she had given him permission to go lay down. R. Ex. 5.

LPNs Tina McComas and Todd Jenkins worked the evening shift (3-11 p.m.) on January 24, 1996. They testified that after report they went to open the medication room. Almost immediately they were approached by several patients, complaining they had not received their 2:00 p.m. medications,

and experiencing various degrees of withdrawal symptoms.

Mr. C. reported to Mr. Nida that he had been sitting in the television room waiting for the medication room door to open, when another patient commented to him that he did not look well and to go tell the nurse. Mr. C. approached Grievant in the records room, and told her he felt bad and was having involuntary muscle movement. She instructed him to go lay down, which he did. She did not offer any medication, nor did he refuse any medication. He reported that Grievant never did check on him, and after about an hour he came out again, at which time he made his complaint to Mr. Nida.

Mr. Nida testified that alcohol withdrawal can be life-threatening if not properly managed with medication and treatment. LPNs are aware of, receive policies on treatment and procedures, and are trained in the symptoms of alcohol withdrawal, the dangers associated with it, and the need to administer medications as directed for those symptoms. If patients do not come to the medication room for their medication, LPNs are required either to find the patient or get assistance from a Health Service Worker to find the patient. R. Exs. 7-12.

Mr. Nida consulted with HSAU Administrator Penny Koontz, the Division of Personnel, and administrators at other facilities regarding what steps to take with regard to Grievant's misconduct. Mr. Nida also spoke several times with Grievant. The matter was considered for several days, and the decision to dismiss Grievant was made on February 1, 1996. Grievant was dismissed by letter dated February 1, 1996, for grossmisconduct. The letter indicates Grievant's misconduct demonstrated willful negligence and a willful disregard of standards of behavior which the employer had a right to expect of its employees, citing several policies which Grievant had violated by her actions, such as failing to document accurately, failing to follow physician's orders, and failing to take vital signs. R. Ex. 13. Mr. Nida testified this was the first time in his many years of experience where a nurse basically made the decision to conduct personal business over the safety and welfare of a patient, thus willfully neglecting the care of that patient. He testified that failure to document alone would not normally be grounds for discharge. He also testified there were instances where medications had not been given in the past because of other activity on the unit, but never because the nurse was engaged in personal business.

Grievant does not dispute the incident occurred as described on January 24, 1996, except she denies Mr. C. was exhibiting alcohol withdrawal symptoms serious enough to warrant any intervention other than advising him to go lay down. Grievant testified she would do the same thing

again if a patient complained in the same manner as Mr. C. had on January 24, 1996. Further, Grievant asserts the two substance abuse counselors who were present with her in the records room had some duty to inform her that they observed Mr. C. in distress, and that their failure to do so somehow serves to absolve her of any individual duty to Mr. C. While it is certainly curious why those two individuals did not speak up at the time, their action or inaction in no way absolves Grievant of her duty as the nurse in charge to properly care for her patients. Grievant also asserts that dismissalis too severe a punishment given her extensive work history, and otherwise unblemished record with the HSAU.

Based upon the foregoing and all of the evidence of record, the following findings of fact and conclusions of law are made.

Findings of Fact

1. Grievant was employed as a Licensed Practice Nurse II ("LPN II") with the HSAU for ten years, until her termination for gross misconduct on February 1, 1996. R. Ex. 13.

2. The HSAU closed permanently on December 31, 1996.

3. On April 28, 1992, Grievant signed a job description form for an LPN II at the HSAU. This form lists examples of work expected of an LPN II, such as: "[a]dministers medications to clients at a basic safe level of practice. . . [a]ssesses client's need for medication and/or drug seeking behaviors and takes appropriate action. . . [a]ssesses clients for detox symptoms, evaluates vital signs, documents assessment and takes appropriate action. . .[t]ranscribes and carries out physician's orders correctly." R. Ex. 9.

4. On January 24, 1996, Grievant failed to administer the 2:00 p.m. prescribed medication to eight clients of the HSAU's Detoxification Unit. R. Exs. Nos. 1, 2.

5. Shortly after 2:00 p.m. on January 24, 1996, client Mr. C. came into the medical records room and told Grievant that he was not felling well and that his arms and legs were moving involuntarily. A physician had ordered that Mr. C., as well other clients, be given a 2:00 p.m. medication treatment of Ativan. Grievant had not given Mr. C. his 2:00 p.m. Ativan as scheduled.

6. Two substance abuse counselors, Lana Gerlach and April Rayburn, were in the records room with Grievant when Mr. C. approached complaining he was not feeling well. Both Ms. Gerlach and Ms. Rayburn observed Mr. C. was having visible withdrawal symptoms.

7. When Mr. C. reported his symptoms to Grievant, she did not take his vital signs, did not give him his 2:00 p.m. medication, or report his condition to a physician. Grievant told Mr. C. to go lay down and she would check on him in about a half-hour. Grievant had not checked on Mr. C. at the end of her shift at 3:00 p.m.

8. During this time period, there was nothing else going on in the Unit which would have prevented Grievant from caring for Mr. C., or from checking on his condition before the end of her shift.

9. Shortly after 3:00 p.m. on January 24, 1996, Mr. C. reported to Mr. Robert Nida, the Detoxification Unit's Director of Nursing, that he was not feeling well. Mr. Nida assessed Mr. C.'s condition and concluded he was exhibiting significant withdrawal symptoms, including tachycardia (rapid heart rate), hypertension, tremors, and a ruddy complexion. Mr. Nida determined Mr. C. was very near his seizure threshold and immediately contacted the Unit's physician and had medication administered to Mr. C. R. Ex. 5.

10. Mr. Nida conducted an investigation of the January 24, 1996, incident involving Mr. C. and concluded Grievant had violated several policies and directives of the HSAU, including “Medication Administration”, “Monitoring the Client with a Physical Complaint”, “Vital Signs”, and “Physician's Orders.” 11. Following discussions with other health care professionals and the Division of Personnel, Mr. Nida and HSAU Administrator Penny Koontz determined that Grievant's failure to properly assess and treat patient Mr. C. amounted to gross misconduct and that dismissal was warranted.

12. According to State and Federal regulations, the HSAU reported the January 24, 1996, incident to the West Virginia State Board of Examiners for Licensed Professional Nurses. On August 20, 1996, Grievant entered into a Consent Agreement with the Board, which placed her on probation for two years. As part of the Consent Agreement, the Board made Findings of Fact and Conclusions of Law consistent with the HSAU's position in this matter. R. Ex. 14.

Conclusions of Law

1. In cases dealing with disciplinary matters, the burden of proof rests with the employer to prove the charges by a preponderance of the evidence. Schmidt v. W. Va. Dept. of Highways, Docket No. DOH-88-063 (Mar. 31, 1989).

2. Dismissal of a civil service employee must be for "good cause," which means misconduct of a substantial nature directly affecting the rights and interest of the public, rather than trivial or inconsequential matters, or mere technical violations of statute or official duty without wrongful intention. W. Va. Code § 29-6-11(12); Oakes v. W. Va. Dept. of Finance and Admin., 164 W. Va. 385, 264 S.E.2d 151 (1980).

3. HSAU trained Grievant to know that alcohol withdrawal can be serious, and possibly life threatening. Grievant's failure to administer scheduled medications and deliberate refusal to treat a client undergoing alcohol withdrawal constituted grossmisconduct. Grievant's misconduct was not trivial or inconsequential. Indeed, the failure to follow physician's orders in dispensing needed medications to patients in a hospital, and especially to a patient complaining of the exact symptomatology for which the medications are prescribed, is an extremely dangerous example of misconduct which directly affects the rights and interest of the public.

4. The HSAU has proven by a preponderance of the evidence that Grievant engaged in gross misconduct when she failed to properly treat Mr. C. and the other eight patients on January 24, 1996.

5. Mitigation of the punishment imposed by the employer is extraordinary relief and is granted only when there is a showing that a particular disciplinary measure is so clearly disproportionate to the employee's 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. Overbee v. WVDHHR/Welch Emergency Hosp., Docket No. 96-HHR-183 (Oct. 3, 1996). See also Parham v. Raleigh County Bd. of Educ., Docket No. 91-41-131 (Nov. 7, 1991).

6. The work record of a long time civil service employee is a factor to be considered in determining whether discharge is an appropriate disciplinary measure. Buskirk v. Civil Service Comm'n, 332 S.E.2d 579 (W. Va. 1985). While Grievant's ten-year work record with HSAU is good, her conduct was such that her length of service cannot serve to mitigate the discipline imposed. In addition, Grievant's testimony that she would pursue the same course of action if faced with a similar situation regarding Mr. C. serves to demonstrate that Grievant has not learned from her mistake. 7. The HSAU did not abuse its discretion in dismissing Grievant for her acts of gross misconduct. Dismissal for gross misconduct is appropriate "where there is a continuing danger to persons or property or to the orderly conduct of the affairs of the agency." DHHR Policy Memorandum 2104 (Jan. 1, 1995). Grievant's deliberate refusal to treat HSAU patients posed a

continuing danger to those and other patients, warranting dismissal.

8. Grievant failed to prove by a preponderance of the evidence that her dismissal was the result of any harassment on the part of the HSAU.

9. Grievant failed to offer any evidence of any other employee who had not been disciplined for a similar offense. Grievant failed to prove by a preponderance of the evidence that her dismissal was the result of disparate treatment.

Accordingly, this grievance is **DENIED**.

Any party or the West Virginia Division of Personnel 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.

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MARY JO SWARTZ

Administrative Law Judge

Dated: May 19, 1997

Footnote: 1

Harassment is defined as "repeated or continual disturbance, irritation or annoyance of an employee which would be contrary to the demeanor expected by law, policy and profession." W. Va. Code § 29-6A-3(l). Grievant did not identify any other action or conduct, other than her dismissal, on the part of her employer which she alleged constituted "harassment." While Grievant certainly was disturbed, irritated and annoyed by her dismissal, this one action on the part of her employer cannot support a "harassment" claim.

With regard to her disparate treatment claim, Grievant did not identify any other employee or employees who engaged in similar conduct, but were not disciplined in any manner by the employer. Thus, Grievant's disparate treatment claim must also fail.